SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

MAJOR RESEARCH PROJECT

A Qualitative Investigation of the Co-Construction of Therapeutic Goals in a CBT Framework

Submitted by Dr Richard White to the University of Exeter

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I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other University.

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LITERATURE REVIEW

The Process of Therapy Goal Co-Construction in Cognitive Behavioural Therapy

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Abstract

Background: Therapy goals are an important part of Cognitive Behavioural Therapy (CBT). It has been demonstrated in the research literature that goals can have an impact on therapy outcomes and impact wider aspects of an individual's life. Despite the importance of goals in therapy, there has been very little process-focused research investigating how goals are co-constructed by therapist and therapy client.

Objectives: This review summarises and synthesises the literature examining goal-setting and therapy outcomes, with a focus on the papers examining the process of goal-setting in a therapy setting.

Method: Systematic review of all literature to date using Web of Science, PubMed, PsycInfo, and PsycArticles databases with a narrative discussion.

Results: Nine papers were reviewed, one utilising a qualitative methodology and eight using a quantitative design.

Conclusions: There is a relatively small number of studies investigating the process of goal setting in therapy, with only one study to date found that looks specifically at the process of goal setting. The results suggest that factors such as the therapeutic alliance and collaborative goal setting can influence the process of goal setting, as can how a therapist uses language within the goal-setting process. However, the relative lack of literature means that the focus in the majority of cases is on the content of goal setting, or how goals should look or be discussed, as opposed to how this process unfolds in a therapeutic setting, with many emphasising the importance of the therapist in the formation of goals. Areas for further research are outlined.

Keywords: Clinical Psychology, Cognitive Behavioural Therapy, Therapy Goals, Therapy Process.

Introduction

Overview

Goal setting is a core part of therapies such as Cognitive Behavioural Therapy (CBT; Beck, 1979). Its aim is to collaboratively create a number of benchmarks by which therapy outcome can be evaluated in order to promote investment in the therapeutic process and meaningful outcomes for the client (Michalak & Grosse Holtforth, 2006). Therapy goals can be reviewed and changed during therapy as necessary. They can provide a direction to treatment and also give motivation to the client to continue therapeutic work outside of the sessions and after formal therapy sessions have concluded. There are suggestions in therapy manuals about what makes a good goal or set of goals and directions in therapy manuals around more general processes of conducting therapy, such as taking a collaborative stance and promoting the client as an expert in their own situation (Dimsdale, 1975).

Definitions

Various terms are used when describing goals. The relevant distinction here is between personal goals and therapy goals (typically referred to as treatment goals in the literature). They are not mutually exclusive; treatment goals can be considered as a sub-set of personal goals (Michalak & Grosse Holtforth, 2006).

Personal goals. Personal goals refer to the aims and choices that an individual makes with the aim of reaching a personally meaningful end state (Karoly, 1993). They comprise objectives across contexts such as family, friends, occupation and health. They are thought to govern people's behaviours, thoughts and emotions (Austin & Vancouver, 1996) and can provide a structure and orientation to an individual's activities in life (Michalak & Grosse Holtforth, 2006).

Therapy goals. Therapy goals are what a client and therapist agree to work toward achieving in therapy. They can be about specific behavioural changes a client wants to make

and are agreed collaboratively by therapist and client (Grosse Holtforth & Grawe, 2002). As they are constructed by both therapist and client, they can be viewed as goals for both client and the therapist (Michalak & Grosse Holtforth, 2006). The functions of treatment goals are thought to range from providing guidance to the therapy content, to balancing power in the therapeutic alliance (Dimsdale, 1975). They are considered in the clinical literature to be co-constructed by therapist and client through a process of reflection, discussion and clarification (Foster & Mash, 1999).

Types of Goals and Links to Outcomes

Research has shed light on some characteristics of goals which are positively associated with goal attainment. Goals in the therapeutic literature typically centre on SMART goals (specific, measurable, attainable, realistic and timely; Doran, 1981; originally from management literature) and / or collaborative goals without specific criteria (Beck, 1979; Horvath & Greenberg, 1989). Below I give an overview of some salient factors in "good goals" and descriptive categories for therapy goals from the research literature. It is notable that the definition and classification of therapy goals is an ongoing area of research (e.g. using tools such as the Bern Inventory of Treatment Goals; Grosse Holtforth & Grawe, 2002).

Avoidance and approach goals. Avoidance goals are concerned with avoiding a negative outcome, e.g. "Do not get anxious", while approach goals are associated with approaching a positive outcome, e.g. "Be more confident" (Elliot, 1999). These types of goals have a differential impact on therapeutic outcome. Avoidance goals are associated with difficulty making progress towards goals and not achieving goals relative to approach goals, with a knock-on effect to personal wellbeing (Elliot & Sheldon, 1998).

Disorder typical goals. Research shows that client's personal and therapy goals can vary based on their psychopathological symptoms (Schulte & Eifert, 2002). For example,

people with a diagnosed eating disorder have more goals around coping with symptoms of the disorder, e.g. having fewer episodes of binge eating (Michalak & Grosse Holtforth, 2006).

Patient and therapist concordance. Agreement between therapist and client on therapy goals is associated with improved therapy outcomes (Tryon & Winograd, 2001), but is rarely observed in studies investigating this link (Dimsdale, 1975).

Goal self-concordance. Goals need to fit with intrinsic motivations and ideas of what is personally important (i.e. be self-concordant) in order for them to lead reliably to successful goal attainment and investment in striving towards goals (Sheldon & Kasser, 1998). Goals associated with external reward or external pressure are less likely to lead to goal attainment as intrinsically motivated goals (Ryan & Deci, 2000). Goals that fit well with personal motivations have also been shown to lead to increases in subjective wellbeing (Sheldon & Elliot, 1999).

Summary

Therapy goals are an important part of therapy and there is research about the content of goals and what makes good therapy goals. However, there is no clear systematic literature review of the factors influencing the process of goal-setting in therapy, specifically CBT, and there is no systematic review and little research on what factors influence the process of goal-setting in therapeutic spaces. Understanding this process is crucial in a therapeutic context as the type of goal formed is thought to impact therapeutic outcomes (Beck, 1979).

Aims of the Review

The aim of this review it to complete a systematic review of the literature to determine (a) whether or not there is a substantial body of research investigating the process of goal setting in therapy and (b) what research that does exist shows about the process of goal setting.

Methods

This systematic review follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines for reporting literature reviews (PRISMA, 2009)

Literature Review Question

What factors are associated with the process of therapy goal construction? The above question is directly relevant to the research aims. The gathering of evidence of factors that influence therapy goals will serve to inform the analytical framework for interpreting data collected in the empirical chapter of this thesis. It will also serve to provide a full description of the research topic, allowing a clear justification of relevance and importance of the selected topic. As goal setting is relevant to the field of personal goal setting and therapeutic goal setting, care will be taken to select the most relevant papers.

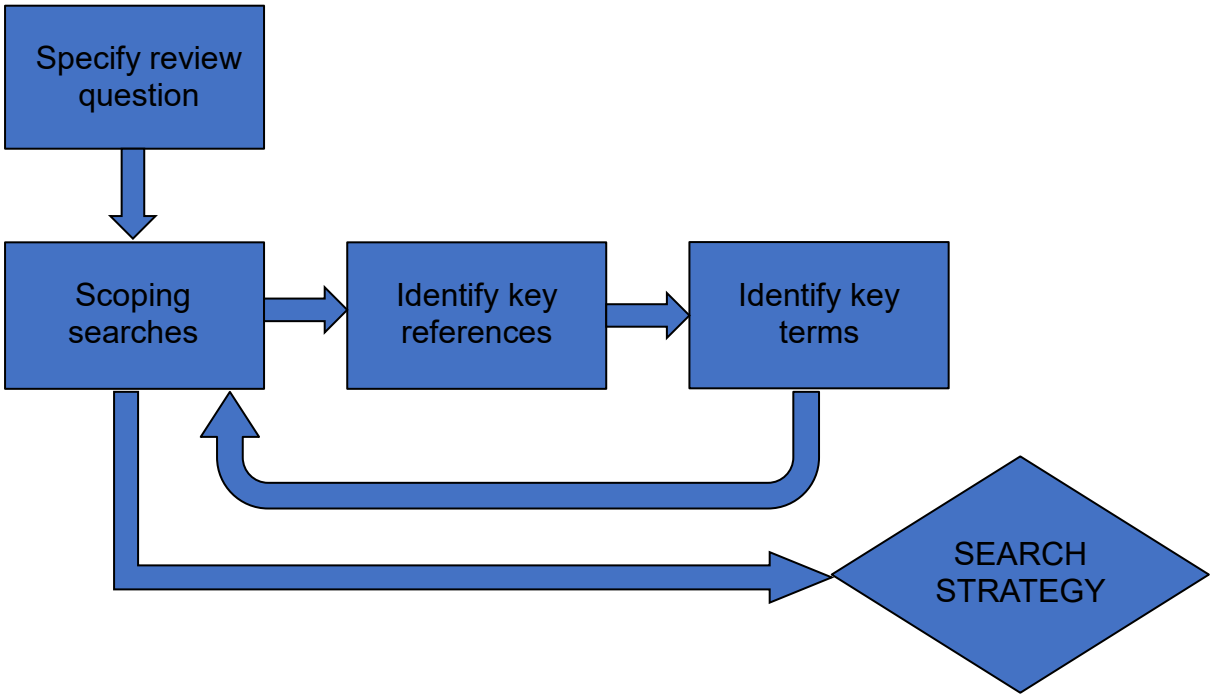
Search Strategy

As I am investigating goal setting within therapy, in order to keep a focus I am primarily concerned with finding journals and articles about goal setting in the context of therapy, as opposed to the wider literature about goals and goal setting in relation to e.g. weight-loss, and performance goals in personnel management. As such the following databases were searched: Web of Science, PubMed, PsycInfo, and PsycArticles.

To supplement this, the references on key articles identified were followed and qualitative journals were checked more intensively to find relevant research.

Search terms. Journal papers from basic scoping indicated that the following key terms are most commonly used when discussing therapy goals, allowing a wide spectrum of papers to be flagged up as potentially relevant: (Goal* OR task* OR objective*) AND (therap* OR psychotherap* OR treat* OR counsel*). A formal scoping search was used to help refine the search terms and screening criteria to produce an appropriate number of papers to analyse. The plan followed the below process:

Figure 1. *Search Strategy Flow Diagram*



The initial search returned 3,282 results, indicating these criteria were too broad. As such, CBT as a search term, e.g. (CBT OR cognitive OR behavioural OR behaviour) was introduced. The second search yielded 162 results, after removing replicas and foreign language papers that were not previously removed from the searches, this left a final list of 112. The search was undertaken for papers published up until July 2018.

Screening procedures including inclusion and exclusion criteria. In order to narrow down the papers to the most relevant, the inclusion and exclusion criteria in the table below were be used. In accordance with PRISMA guidelines (PRISMA, 2009), titles and abstracts were first scanned, this reduced the number down to 52. Then, a second-stage search on the full texts was completed to narrow filter down the papers, this left a final number of nine papers (see Figure 2).

Table 1. *PRISMA Inclusion and Exclusion Criteria*

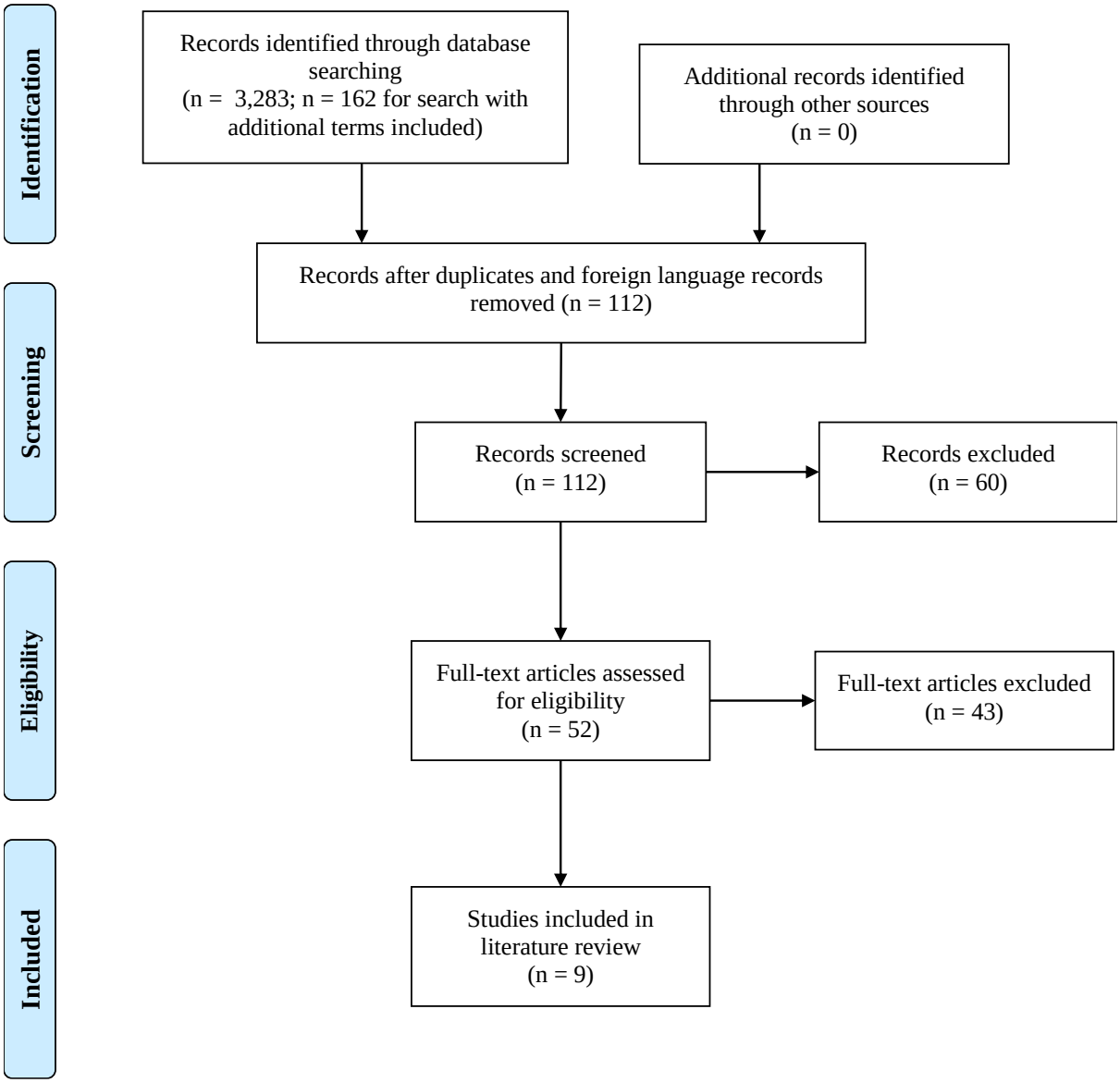
	Inclusion criteria	Exclusion criteria
Participants	• Therapists and clients in therapy dyads. • Any diagnosis and ages will be relevant.	• Group psychotherapy.
Interventions	• Research is concerned with the construction of goals. Goals will be defined as the overall therapy goals set collaboratively by therapist and client. • Research that reports and analyses data gathered directly or indirectly from therapy. Directly would include the analysis of audio tapes / transcripts of therapy. Indirectly would be retrospectively asking the therapist and/or client about their experiences through questionnaire, semi-structured interview or unstructured interview. • Research that mentions, measures or discusses factors associated with goal setting including but not limited to: therapeutic model, therapeutic alliance, client personality, client / therapist previous experiences of therapy.	• Research concerning the more "micro" aspect of goals such as agenda setting and negotiating between session tasks.
Comparisons	• Not applicable to the search as the focus is on the process and content of discourse.	• Not applicable.
Outcomes	• Not applicable as the focus is on the process of goal setting as opposed to the results of goal setting.	• Not applicable.
Study Design	• Any, as there could be relevant information from qualitative and quantitative designs.	• Research reported in a non-English language.

It is worth noting that one of the exclusion criteria proposed before this search was undertaken was removed, it is as follows: "Research investigating goals that are not set by therapist and client through discussions in therapy session." This was removed as there were a number of relevant and high quality papers returned that did not follow this guideline; it seems that one of the common designs in the field of goals research is to examine goals that were prospectively or retrospectively set by therapists and therapy clients individually, as

opposed to recording those actually agreed in therapy, i.e. using a more experimental design vs. a naturalistic one.

I have searched to see if a similar literature search has been completed, it has not. Recent reviews have not focused on psychotherapy and have not looked at the discourse that leads to goal-creation but focuses more on the subsequent impact of the goals (e.g. Locke & Latham, 2002).

Figure 2. *Flow-chart of Paper Selection*



Evaluation criteria. In order to determine the quality of the articles I used the following criteria:

a. Contributory: advances knowledge or understanding in its stated area
b. Defensible in design: the design matches the research questions
c. Rigorous in conduct: systematic and transparent collection, analysis and interpretation
d. Credible in claim.
e. Relevant to my topic and review question.

The first 4 criteria were adapted from Spencer et al. (2003) and the fifth was added in order to assess relevance to my literature review question. I will rate studies on these five criteria on a numerical scale of one to three (poor, moderate, good) and present this information in a table. These criteria were generally quite broad and I did look to specific guidance to help try to assess the individual components in a consistent way. For example, I looked at the Critical Appraisal Skills Program (CASP) criteria in order to evaluate the quality of qualitative research and quantitative research. However, criteria specific to these guidelines were not included in final ratings, as (a) the research was a mixture of qualitative and quantitative, making numerical comparison difficult, and (b) the initial ratings were robust and simple to understand, making them well suited to their purpose.

The selection of papers for full text review, the final papers that made it into review and the quality ratings for the papers selected were not rated by a second person.

The quality ratings have been used to inform the narrative synthesis: specific issues and themes in the review of the papers have been identified based on ratings.

Table 2. *Summary of Reviewed Literature*

Reference (country of origin)	**Aim**	**Design/ method (Quality rating)**	**Data (Quality rating)**	**Analysis (Quality rating)**	**Risk of bias / limitations (Quality rating)**	**Findings and clinical relevance (Quality rating)**	**Score (out of 15)**
1. Arnow and Castonguay, 1996 (USA)	Investigate the difference in goal setting between CBT and psychodynamic therapists	2x2 Experimental design CBT and psychodynamic therapists respond to vignettes about clients: 2x interpersonal difficulties and 2x non-interpersonal difficulties (2)	CBT n = 15 Psychodynamic n=15 Therapeutic goals suggested by therapists Approaches to achieving goals suggested by therapists (3)	Coding of verbatim responses: symptomatic, intrapsychic, interpersonal (goals); directive, non-directive, "therapeutic alliance enhancing" (strategies) Chi-squared tests (2)	No exploratory data analysis: responses are coded into a-priori determined categories with little consideration of those that don't fit the pattern. No adjustment for familywise error Unclear method of checking coding Psychodynamic Therapists have double years of experience of CBT therapists (2)	No difference in symptomatic focus between therapies Psychodynamic more interested in intrapsychic goals No difference in directive strategies; psychodynamic more non-directive strategies There is more overlap than expected in the goals and techniques used by psychodynamic and CBT therapists (2)	11
2.Crane et al., 2011 (UK)	Explore the links between therapy and life goals	Randomised controlled trial: MBCT vs waitlist control; life goals measured pre/post Specificity and achievability of goals measured Sample was depressed patients (2)	MBCT n=14, TAU n=13 Self-report scores pre and post for therapy outcomes and goals (3)	ANOVA used to investigate differences between groups for goal specificity and goal likelihood (3)	Small sample size Mechanism of mediation between mood and goal achievability not explored in detail (3)	Difference between groups as predicted: MBCT saw an increase in specific goals with higher ratings of achievability Change in mood not a relevant factor for specificity but is for achievability (2)	13

3.Ekberg and LeCouteur, 2014 (Australia)	To investigate the co-implication of clients in the decision making processes for behavioural change (i.e. collaborative goal setting) in CBT	Conversational analysis (3)	20 therapy dyads, average 56 minutes per dyad, extracted from a period of time on decision making processes for behavioural change (3)	Conversation analysis through extracts (2)	Selection of material not justified No evidence of secondary raters or independent support for analysis (2)	Use of: summarising, and open-questions with emphasis on actions of client re-shapes discussions. Use of language is important in the formulation of collaborative goals, including proactive use of language (e.g. sentence completion) by therapist (3)	13
4.Elliot and Church, 2002 (USA)	Investigate whether approach or avoidance goals have a different impact in change in subjective wellbeing following therapy	Within participants correlational design (3)	96 individuals, self-report questionnaires (2)	Multiple regression modelling (3)	Therapy completers only analysed: goal type influence on completion not explored. Student sample (generalisability) Directionality of effects not possible to say with certainty. (2)	Client expectations for goals will shape their format. More avoidance goals leads to less positive change in subjective wellbeing and lower levels of therapy effectiveness (which includes goal progress) (2)	12
5.James, Thorn and Williams, 1993 (USA)	Investigate goal setting in CBT for chronic pain (headaches) and it's links with outcomes	Randomised treatment manipulation with repeated measures (2)	33 individuals, self-report task (2)	MANCOVA analysing pain outcomes, group membership, and a number of secondary measures. (2)	Limited sample size undermines validity of analysis this complex. Significant number of dropouts from protocol. (2)	Concrete and time-limited goals are effective at reducing pain Imposition of this requirement was enough to ensure goals of this type were formed. (2)	10

6.Jansson, Than and Ramnero, 2015 (Sweden)	Investigate the differences between patients and controls regarding goal setting	Between groups design (2)	Non-patients (n=106), patients (n=147), self-report questionnaires (3)	Prevalence estimates and ANCOVA (2)	Study relies on self-report. Limited information on the mental health population in terms of diagnosis (2)	Clients of mental health services set more goals associated with mental health symptoms and rated themselves as further away from achieving goals (2)	11
7.Michalak, Klappheck and Kosfelder, 2004 (Germany)	Investigate the links between goals and therapy outcomes	Correlational design with repeated measures (2)	72 outpatients with a diagnosis of mood or anxiety disorder, self-report questionnaires (2)	Correlations between responses on measures (3)	Correlational study cannot give a clear idea of directionality of relationship Limited consideration of sources of bias in the study (2)	Measures of optimism for goals and goal striving correlated positively with positive therapy outcomes (2)	11
8.Ryum et al., 2014 (Norway)	To investigate the underlying types of therapy goals	Between participants design (2)	49 outpatients with a diagnosis of a personality disorder (3)	Factor analysis of scores on items of an observational measure of therapy goals (3)	Cases limited to one domain of mental health difficulty Influence of therapy model only considered to a limited extent (3)	Therapy goals were able to be classed as: restructuring of defences, changing affect and building a sense of self and others. (1)	12
9.Schottke, Trame and Sembill, 2014 (Germany)	Investigate the determinants of therapy goals and predictive value for therapeutic success	Naturalistic observation (2)	473 university student outpatients receiving psychological therapy (CBT and psychodynamic therapy) (3)	Coding of therapy goals and correlation with therapy outcomes (3)	No measure of therapy adherence or therapist effectiveness Unclear links between process and outcome of goal setting Unclear if the goals were formed collaboratively (2)	Problem and symptom focused goals correlated positively with treatment outcome Goal concordance between therapist and client was poor (2)	13

Findings

A summary of the nine studies is presented in Table 1, with details for each of the following: aim, design / method, data, analysis, risk of bias / limitations, findings and clinical relevance, and total score.

The immediate result, from the process of searching and narrowing down the search to relevant papers, is that the process of goal setting in CBT, although acknowledged as an integral part of therapy, is not well represented in the research literature. This review returned few relevant studies, of which there was a variance in how closely related they were to the research question. Research into the mechanisms behind goal-setting seems to be a relatively new venture, with the majority of studies being published post 2000. This may coincide with the increasing research agenda for examining the components of psychological therapies in order to learn more about the processes that contribute to specific types of therapeutic change (Collins et al., 2005). Studies focused on the role of goals within therapeutic frameworks, with the research mixing investigating one (n=6; study numbers 2, 3, 4, 5, 6 & 7) or multiple modalities (n=3, study numbers 1, 8 & 9). There was a mix of therapies focused on, but CBT was the most popular (n=5; study numbers 1, 3, 5, 7 & 8).

Aims of the Studies

Reading and comparing the aims suggests that there were three main themes: linking therapy type to goal characteristics; linking goals to outcome; and investigating goal types and the process of goal setting. Studies reviewed here focused on the characteristics of goals (n=6; study numbers 1, 2, 4, 5, 8 & 9) and the attitudes of therapists and clients towards goals (n=4; study numbers 2, 6, 7 & 9). CBT was the most prevalent model examined (n = 5; study numbers 1, 3, 5, 7 & 8); comparing CBT with other modalities approach to goal setting was undertaken in three studies (study numbers 1, 8 & 9). Several studies looked to tie therapy goals with treatment outcomes (n = 4; study numbers 2, 4, 5, 6, 7 & 9).

Linking therapy types to goal characteristics. Arnow and Castonguay (1996) investigated the difference in goal setting between CBT and psychodynamic psychotherapy, in particular, their aim was to look at the relationship between therapy type and whether goals set were intrapsychic, behavioural focused or interpersonal, and whether there was a relation between therapy and the broad process used in goal-setting (directive or non-directive). Similarly, Schottke, Trame and Sembill (2014) aimed to investigate what influences therapy goals and if there are predictive values for their successful accomplishment. They aimed to investigate if there were differences between client and therapist goals, differences between CBT and psychotherapists' goals, and if treatment goals can predict therapy success.

Goals and therapy outcomes. Crane et al. (2011) aimed to investigate whether the receipt of therapy impacts on life-goals and what mediates this relationship. Elliot and Church (2002) aimed to investigate the relationship between avoidance therapy goals and changes in subjective wellbeing following a course of short-term psychotherapy. They also aimed to establish if there were factors mediating this relationship such as the importance of goals to the individual. James, Thorn and Williams (1993) aimed to investigate the link between goal setting in CBT for chronic pain and change in headache pain and use of coping strategies. Michalak, Klappheck and Kosfelder (2004) looked to investigate the links between goals, goal motivation and therapy outcomes. All these studies looked to see the relationship between goals and therapy outcomes.

Investigating goals: types and process. Jansson, Tham and Ramnero (2015) aimed to investigate the differences between patients and controls in the setting of medium term life goals. Ryum et al. (2014) aimed to explore the factor structure of goal setting in short term psychotherapy and cognitive therapy using a pre-designed measure. Ekberg and LeCouteur (2014) aimed to investigate the process of collaboration in the goal-setting process for

behavioural change directed behaviours in CBT, they aimed to highlight the role of conversational practice in the therapy room in this change.

Method and Data Analysis

Two studies employed an experimental design. Arnow and Castonguay, (1996) used a between groups, experimental design which collected therapist responses to clinical vignettes. These responses were coded by the researchers and then Chi-squared analyses were used to test the a-priori predictions of differences between groups. James, Thorn and Williams (1993) used a between participants, repeated measures design, varying the amount of goal-setting advice / guidance across 3 groups (high levels of guidance that must be followed during CBT for chronic pain, open-ended guidance during CBT, and a waitlist control (no intervention, guidance) and looking at how group membership relates to changes in pain intensity and use of coping strategies.

Three studies used data from treatment trials. Crane et al. (2011) used a repeated measures, between groups comparison based on data from a wider randomised controlled trial into the efficacy of MBCT (Barnhofer et al, 2009); they used ANOVAs to investigate the impact of therapy on independently rated measures of goal specificity and patient measured likelihood of achieving goals. Michalak, Klappheck and Kosfelder, (2004) used a between groups design to look at the relationship between goals, psychological state and therapy time-point (start and mid-point of therapy). Schottke, Trame and Sembill (2014) used a between participants design to examine the therapy goals of 473 psychotherapy outpatients. The goals were obtained from free text written by the client and therapist separately pre-therapy. These goals were then coded by trained raters according to the BIT-T (Grosse & Grawe, 2002). A series of non-parametric tests using spearman's Rho was used for the therapist – client congruence, and a MANOVA with two within-participants factors (source - therapist or patient, and category of the goals) and one between-subjects factor (therapy orientation) was run to

look at relationship of therapist / client goals with therapy domain and treatment type. Hierarchical multiple regression was used to look at the influence of these variables on therapy outcomes.

Jansson, Tham and Ramnero, (2015) used a between groups design, investigating the differences in goal setting by asking patients and non-patients to fill out a goals inventory. Between group analysis consisted of a multi-step logistic regression analysis to find a model that allows the most accurate prediction of group membership (patient, non-patient) based on the types of goals that they selected. Ryum et al. (2014) used a between participants design to look at the factor structure of therapy goals measured through an observer-rated measure of therapeutic goals. Tapes of therapy were coded by trained raters with a high level of concordance (intraclass correlation >.70). A structural equation modelling approach was used to fit an a-priori designed model of latent variables thought to underly the measure.

Unique in the studies reviewed, Elliot and Church (2002) used a repeated measures design and analysed the data they collected using regression analysis and mediational analysis. Ekberg and LeCouteur (2014) analysed therapy recordings using a qualitative, conversational analysis protocol in order to try and identify how conversational techniques were being used to shape collaboration during goal-setting. This was the only study to use a qualitative approach in this review.

Limitations and Bias

The main limitations of the research can be classified in three main ways: conceptual issues with goal classification, lack of focus on clinical process, and methodological flaws.

Conceptual issues. One limitation was the imposition of top-down ideas of the phenomenology of goals with little consideration of why goals were being classed this way. For example, some studies were pre-occupied with the rating of goals but did not consider the

important features of the goals, while those that were concerned with the important features of goals provided little in the way of process analysis.

Arnow and Castonguay (1996) exclusively considered goals from the perspective of the therapist. Crane et al. (2011) did not use any measures of goals from the therapy that they investigated themselves, but rather used a goal-suggestion process, which may or may not relate to goals in therapy, and they did not consider the impact of these on the validity of their results. Counter to this, Ekberg and LeCouteur (2014) use of a qualitative methodology meant that the study did not make any assumptions or interpretations, as it was more principally concerned with the content of goals in a naturalistic setting. However, the process by which they selected excerpts was not fully explained and therefore bias cannot be ruled out.

Michalak, Klappheck and Kosfelder (2004) when assessing goals, did not consider the goals for therapy, although this would have been possible to measure. Instead, they looked at patient-generated goals using a prompting exercise and then marked the goals associated with symptomology as therapy goals. This differs from some of the other research reviewed here that looks at the range of therapy goals beyond symptom-focused goals (e.g. Arnow & Castonguay, 1996). Ryum et al. (2014) in their analysis privileges their view on goals as classifiable from the psychodynamic perspective. They do not consider the other ways in which they could conceptualise goals and are, similar to Michalak, Klappcheck and Kosfelder (2004), not as wide-ranging as other studies. This presents the same conceptual issue that goals are being defined in a top-down manner in a limited way, without considering the range of ways that goals can be examined and in some cases not involving both therapist and client, who co-construct goals together.

Lack of focus on clinical process. Perhaps unsurprisingly given the design and above points, many of the studies did not explicitly consider the process of goal-setting and instead looked at the content of goals, barring James, Thorn and Williams (1993) who manipulated the

goal setting process (although they were more primarily interested in outcomes) and Ekberg and LeCouteur (2014) who investigated the process of goal setting using CA. However, this does not mean that there are no features of goal setting process that can be inferred by these studies; for example, Schottke, Trame and Sembill (2014) highlight the importance of therapist-client relationship in goal-setting. The implications of the studies included in this review for the process of goal-setting will be covered in the discussion section.

Methodological issues. Several the studies had methodological flaws, ranging from sample sizes which may undermine the validity of conclusions made, to specific questions about methodological or analytical procedure. Arnow & Castonguay (1996) ran multiple Chi-squared tests without a correction to the p level for familywise error. Using a more conservative p value, such as 0.01 means that for many of their research hypotheses, the null hypothesis cannot be rejected, in particular, there would be no evidence of a difference in goal setting between the CBT and psychodynamic groups, bar the increased use of intrapsychic goals for psychodynamic therapy and the preponderance to use exploratory techniques in the therapy itself.

Crane et al. (2011) had a very limited sample size for the sophistication of the analysis that they used. They ran multiple ANOVAs on data from 27 people, often splitting the sample into multiple groups. Although it would not be possible to estimate an appropriate sample size for the study based on their reported statistics, it is reasonable to suggest that the power of the study to accurately detect differences was low.

Elliot and Church (2002) measured goals prior to therapy started and did not check in with the goals that were set in therapy. This suggests that the results are an indirect measure of goals and what they were measuring may have been a proxy for a personality type or severity of psychological dysfunction (Ryum et al., 2014). If this were the case, their mediation analysis would be flawed as they did not consider the role of the therapist (outside of therapist

satisfaction) in the formation of goals, which resulted in symptomatic change. There is very little data on the goals that people set, and, given the other research cited here, it needs to be considered whether therapist agency can influence people in a varying way depending on therapeutic alliance and other factors (DeFife & Hilsenroth, 2011).

James, Thorn and Williams (1993) considered the clinical process involved in goal setting in their design, by imposing in a top-down way the behaviour of therapists during the process. The difficulty is that as they did not have a control-group for goal-setting process, it is hard to see how the selected methods of goal-setting would differ to in-vivo goal setting. Jansson, Tham and Ramnero (2015) provided limited information on the diagnosis and severity of the population in question. They do measure general anxiety and depression in both groups, but they do not consider this a covariate in their analyses. This is important to their methodology as follows: mental health difficulties such as anxiety and depression are thought to be distributed in the general population in an even way (Keyes, 2002). As such, dividing the population into groups (patient and non-patient) in this study sets a false dichotomy. This is important as, if there is a relationship between mental health symptoms and goal setting, then it would be reasonable to expect this to vary in a linear way with increasing symptoms of mental health. Therefore, it may have been more appropriate, given their design, to embrace the range of symptom severity that they have across both groups and instead perform a regression analysis using just one group.

Michalak, Klappheck and Kosfelder (2004) used a between groups design to examine differences between two different therapy timepoints. This is a limitation as it is a sub-optimal design: a within-subjects repeated measures design would have allowed each participant to be their own control, thus improving the power of the study. Indeed, they found that their two groups of participants significantly differed on key characteristics, such as age, session outcomes, and type of diagnoses. This undermines the validity of the conclusions of this study.

Ekberg & LeCouteur (2014) recruited 20 therapy dyads and they had over 16 hours of therapy data to analyse. Given the range of data and the fact that only limited material was selected for presentation, the process by which the data was selected is crucial to assessing the validity of the analysis and subsequent discussion. Without a detailed description of this process it is hard to say with certainty that potential bias from the researcher can be ruled out.

Main Findings and Implications

Therapy outcomes and goals. Elliot and Church (2002) correlated changes in wellbeing with the presence in pre-therapy specified avoidance goals. Their findings showed that there was a relationship, namely that clients with more avoidance goals experienced a smaller increase in subjective wellbeing (SWB) than those with fewer avoidance goals, and that this relationship was mediated by satisfaction with therapy and perceived therapy effectiveness. James, Thorn and Williams, (1993) found that the use of more structured goal setting led to improvements of therapy efficacy. Crane et al. (2011) found, using a procedure that differs from the other studies, that the receipt of therapy changes the goals that individuals generated during goal-setting task post therapy, with participants that received therapy rating their goals as more attainable.

Therapy types and goal types. Arnow and Castonguay (1996) found that different therapy types do not necessarily differ in terms of how the therapist would approach goals: they generally emphasise symptomatic goals and interpersonal change. Relevant to this review, CBT may have an emphasis on symptomatic change, but goal emphasis may change given client presentation. Schottke, Trame and Sembill (2014) showed that there was little congruence between therapist and client treatment goals and therapists formulated double the number of goals than clients. They also found that CBT therapists formulated many more goals to do with symptoms and wellbeing, whilst psychotherapists set more goals to do with personal growth.

Therapist agency. Ekberg and LeCouteur (2014) emphasised through their analysis the value that the therapist brings in the shaping of the conversation, indeed their choice of excerpts reflects this (with the caveat of their reporting of methodology as covered in the previous section). The findings that the therapists use a number of proactive techniques and have a high deal of agency within the process of goal setting is therefore not surprising. They showed that subtle and minor processes can influence the final form of therapy goals and the suggestion is that these nudges come from the unspoken (in these extracts) rules governing what good therapy goals look like (Rubin, 2002).

Related to this, Schottke, Trame and Sembill (2014) found that patient goals pre therapy are predictive of therapy outcome, but that this relationship is less robust when therapist pre-therapy goals are considered. In conjunction with the findings of Ekberg and LeCouteur (2014), this suggests that although important, therapist agency isn't the only factor influencing goal setting. However, one of the important points to note is that there was little in the majority of studies to measure if the therapy that was being undertaken was adhering to gold-standards for goal-setting. This point relates closely to that of therapist agency as without a confirmation that the therapy is as effective as it could be, it would be hard to know if the results of a strong influence of patient characteristics regardless of therapeutic intervention is due to the strength of those characteristics or the lack of high standards of clinical practice.

Personal factors in goal setting and domains of goals. Ryum et al. (2014) found in their study that the goals they measured using the ATOS can be summarised along the lines of 3 main domains of goals, which are informed by theoretical literature on short term psychotherapy. These domains are the restructuring of defences, restructuring of affect and restructuring of self and others. These are all symptom domains, it is worth noting that, as described above, the way in which goals were measured in this study gives an emphasis to symptomatic goals to the exclusion of other categories of goals. Jansson, Tham and Ramnero

(2015) found that a higher tendency to endorse goal categories related to depressive symptoms, substance misuse, being in a relationship, and coping with somatic problems, was associated with higher odds of being a client of mental health services, whilst higher endorsement of goals categories relating to eating and connectedness / intimacy is associated with decreased odds of being a client.

Discussion

The review reflects the breadth and diversity of the goal-setting literature, as well as the relative lack of qualitative studies investigating the process of goal setting. The studies investigating life-goals. However, this is not to say that this research is irrelevant, indeed, Crane et al. (2011) showed that there is an existing overlap between life and therapy goals, and so it stands to reason that the processes behind the formation of different types of goals will have commonalities.

Research Strengths and Implications

There were a number of strengths in the studies reviewed and broad variety of methodologies used. For example, Arnow and Castonguay (1996) used a novel approach not taken by other studies to try and replicate the naturalistic conditions of therapy through the use of coding and vignettes, indeed, there was only one observational study that looked at in-vivo goal-setting (Ekberg & LeCouteur, 2014).

Jansson, Tham and Ramnero (2015) showed a sophistication of analysis in looking to try and find the kinds of goals that clients, vs non-clients, set. Their use of logistic regression was unique amongst the studies in the review and allowed the differences that personal characteristics can have on the types of goals that are set / endorsed. This brings into mind the importance of narratives from mental health difficulties and, in relation to previous points about the agency of therapists and processes they may undertake to form goals, seems that, at least from the perspective of symptom goals in CBT, that clients will be bringing a lot of this focus

anyway, similarly with the interpersonal goals. These results, taken with those of James, Thorn and Williams (1993) reinforces the idea that there will be powerful narratives on the content and form of goals, but that in the room the discourse may be marked by commonality, it will be interesting to consider if there is much discourse around conflict / introducing these ideas, or more on the shaping / altering of pre-existing narratives of what goals look like into a co-constructed whole.

Ryum et al. (2014) used a rigorous method to both ensure that the therapy in the trial they examined was of a high standard, and that the observation measures they used were valid and reliable across raters. The therapy involved frequent review by videotape, with a clear protocol for what was to happen if therapy sessions were looking like they were not following protocol or of a sufficient quality. The rating involved training on a published measure (the Achievement of Therapeutic Objectives Scale, McCullough et al., 2003) by qualified clinicians with suitable training and support, and inter-rater reliability testing. The protocol for rating also incorporated the use of dual marking, randomised presentation of clips and frequent breaks. Schottke, Trame and Sembill (2014), although their rating method was not as robust as Ryum et al. (2014), had a large sample size and a very thorough measure of goals.

Insights into Goal-Setting Process

Crane et al. (2011) gives an insight into the impact of therapy on how individuals subsequently come to set goals. This emphasises the importance of the process of co-construction in having a long-term impact on narratives of what goals look like as well as the approach and optimism towards goals.

James, Thorn and Williams (1993) used an experimental design the required therapists to set goals in a specific way and then examined the impact of this. The manipulation of this variable helped to account for the effect of other variables, such as the goals that participants bring, different therapists might bring, and the implication of factors such as therapist

effectiveness (DeFife & Hilsenroth, 2011). As such, it goes to show how a variable such as specificity can go above and beyond the oft cited value of therapeutic alliance building as the value of goal setting. Indeed, a forced agenda can be conceptualised as counter to the therapeutic alliance (Kolb et al., 1985)

Michalak, Klappheck and Kosfelder (2004) with their demonstration of the importance of the intrinsic motivation for goals and optimism for goals, prompts the question of whether these narratives occur in the context of the process of goal setting, and so whether or not they are used in the formation and negotiation of goals. This broadens out the mechanisms by which therapy could influence behavioural change through the way that people regard goals. Therefore, when examining process, it will be necessary to consider not only the content of goals as an end-state for co-construction, but also how the stance toward goals is co-constructed, specifically, notions of optimism and self-determination. Although this could be considered as more of a theme, I think it is important to recognise as part of the core of goal-setting, as the narratives of goal content and goal approach are necessarily combined.

Power, Agency and Therapy Process

Arnow & Castonguay (1996) like many of the other studies, is intriguing as for the research to be valid, it is necessary that there is a power imbalance in the therapy room and that the therapist will be fundamental in the content of goals set.

The findings from Ekberg and LeCouteur (2014) highlights the importance of the conversational techniques in the co-construction of goals, and, relevant to this review, the interaction between the influence of theoretical models of goal setting and therapy, and how this underlies the aims of the specific techniques used in the therapy room. Indeed, Ryum et al. (2014) and Schottke, Trame and Sembill (2014) also highlighted the importance of co-construction in the formation of therapy goals.

Related to this, Elliot and Church (2002) showed the importance of the therapeutic alliance and other aspects of positive therapy experience and how they interact with client pre-conceptions of goals. From the goal-setting process perspective, it would therefore be important to be mindful of the influence of therapeutic alliance in the formation of goals, and it would be possible to hypothesis that the use of this alliance in order to challenge narratives and the use of indicators of positive alliance in the room may play a role in the co-construction of goals.

Conclusion

This systematic review has highlighted the breadth and diversity of the clinical goal setting literature, and how studies that are ostensibly investigating the same phenomenon are using a variety of definitions of goals, methodological approaches and methods of analysis. This challenge to synthesising the material has afforded the ability to explore several topics to consider when investigating the process of goal setting in CBT. It has highlighted a relative lack of process focused research utilising a qualitative methodology, and a lack of studies using a naturalistic, discursive approach to investigating goal setting. The findings of the studies reviewed have emphasised the need for such qualitative research, and the demonstration of links between therapy, goals, therapy outcome and wellbeing all emphasises the importance of research in this area.

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Appendix A: Author Guidelines for Behavioural and Cognitive Psychotherapy

Editorial Statement

Behavioural and Cognitive Psychotherapy is an international multidisciplinary journal for the publication of original research of an experimental, or clinical nature that contributes to the theory, practice and evaluation of cognitive and behavioural therapies. As such the scope of the journal is very broad, and articles relevant to most areas of human behaviour and human experience which would be of interest to members of the helping and teaching professions will be considered for publication.

As an applied science the concepts, methodology and techniques of behavioural psychotherapy continue to change. The journal seeks both to reflect and to influence those changes. While the emphasis is placed on empirical research, articles concerned with important theoretical and methodological issues as well as evaluative reviews of the behavioural literature are also published. In addition, given the emphasis of behaviour therapy on the experimental investigation of the single case, the journal from time to time publishes case studies using single case experimental designs. For the majority of designs this should include a baseline period with repeated measures; in all instances the nature of the quantitative data and the intervention must be clearly specified. Other types of case report can be submitted for the Brief Clinical Reports section.

Articles should concern original material that is neither published nor under consideration for publication elsewhere. This applies also to articles in languages other than English.

Sections of the Journal

Main

Reports of original research employing experimental or correlational methods and using within or between subject designs. Review or discussion articles that are based on empirical data and that have important new theoretical, conceptual or applied implications.

Accelerated Publication

The accelerated publication section is intended to accommodate a small number of important papers. Such papers will include major new findings for which rapid dissemination would be of considerable benefit and impact. For example: reports of the results of important new clinical trials; innovative experimental results with major implications for theory or practice; other work of unusually high calibre. If submitting a manuscript to this section you must specify in your cover letter why it should be considered as Accelerated.

Empirically Grounded Clinical Interventions

This section is intended for reviews of the present status of treatment approaches for specific psychological problems. It is intended that such articles will draw upon a combination of treatment trials, experimental evidence and other research, and be firmly founded in phenomenology. It should take account of, but also go beyond, treatment outcome data.

Brief Clinical Reports

Material suitable for this section includes unusual case reports and accounts of potentially important techniques, phenomena or observations; for example, descriptions of previously unreported techniques, outlines of available treatment manuals, descriptions of innovative variations of existing procedures, details of self-help or training packages, and accounts of the application of existing techniques in novel settings. The BCR section is intended to extend the scope of the clinical section. Submissions to this section should be **no longer than 1800 words** and should include **no more than six references, one table or figure**, and an **extended report** that contains fuller details. There are no restrictions on the size or format of the extended report as it will be published online only. It may, for instance, be a treatment manual, a fully detailed case report, or a therapy transcript. If a submission is accepted for publication as a Brief Clinical Report, the author(s) must be prepared to send the fuller document to those requesting it, free of charge or at a price agreed with the editor to reflect the cost of materials involved. The extended document will also be mounted on the journal's website as a PDF format (the document will not be copyedited).

Study Protocols

Protocols of proposed and ongoing trials in behavioural and cognitive therapies will be considered. Your study must be registered and have ethical approval, and proof of this will be required. The abstract should be **structured** under the following four headings; **Background, Aims, Method, Discussion.**

Please use the *Standard Protocol Items: Recommendations for Interventional Trail* (SPIRIT) checklist for protocols of randomised controlled trials (see the reporting standards section below). Manuscripts should be **under 2000 words** at the point of first submission, and include no more than **15 references**, and no more than **three tables/figures in total**. A PDF with additional, unlimited text, figures and tables may be included designated for online only publication.

Reporting Standards

Behavioural and Cognitive Psychotherapy supports standardised reporting practices, consult the following table to ensure your submission meets the reporting standards for your manuscript type. Please include the relevant supporting information (such as diagrams and checklists) with your submission files. See http://www.equator-network.org/reporting-guidelines/ for more information on manuscript types not described below.

The journal also encourages clarity in describing interventions sufficient to allow their replication through the use of the Template for Intervention Description and Replication Checklist (TIDieR).

Randomised Controlled Trial	CONSORT	http://www.consort-statement.org/
Systematic reviews and Meta-Analysis	PRISMA	http://www.prisma-statement.org/
Study Protocols	SPIRIT	http://www.spirit-statement.org/

Preparing Your Manuscript

Articles must be under 5,000 words at the point of submission, excluding references, tables and figures (please see separate instructions for Brief Clinical Reports and Study Protocols). Manuscripts describing more than one study may exceed this limit but please make this clear to the editorial office in your cover letter.

Authors who want a blind review should indicate this at the point of submission of their article, omitting details of authorship and other identifying information from the main manuscript. Authors who do not omit this information will be assumed as submitting a non-blinded manuscript. Submission for blind review is encouraged.

All submissions should be submitted via this portal: http://mc.manuscriptcentral.com/babcp

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APA style should be followed throughout. http://www.apastyle.org/

Abbreviations where used must be standard. The Systeme International (SI) should be used for all units. Probability values and power statistics should be given with statistical values and degrees of freedom (e.g. $t(34) = 2.39$, $p<.001$), but such information may be included in tables rather than in the main text. Spelling must be consistent within an article, using either British spelling (*The Shorter Oxford English Dictionary*), or American (*Webster's New World College Dictionary*). However, spelling in the list of references must be literal to each publication.

In-text references

In-text references should be cited as follows: "...Given the critical role of the prefrontal cortex (PFC) in working memory (Cohen et al., 1997; Goldman-Rakic, 1987; Perlstein et al., 2003a, 2003b)..." with multiple references in alphabetical order. Another example: "...Cohen et al. (1994, 1997), Braver et al. (1997), and Jonides and Smith (1997) demonstrated..."

References cited in the text with two authors should list both names. References cited in the text with three, four, or five authors, list all authors at first mention; with subsequent citations include only the first author's last name followed by et al. References cited in the text with six or more authors should list the first author et al. throughout. In the reference section, for works with up to seven authors, list all authors. For eight authors or more, list the first six, then ellipses followed by the last author's name.

Details of style not specified here may be determined by reference to the *Publication Manual of the American Psychological Association*.

Manuscripts Should Conform to the Following Scheme

1. Title Page

The title should phrase concisely the major issues. Author(s) to be given with departmental affiliations and addresses, grouped appropriately. A running head of no more than 40 characters should be indicated and carried through the document as a header. This should be uploaded as a separate file.

2. Main Manuscript

a. Abstract. Unless a Study Protocol (see separate guidelines), a 250 word abstract should be structured under the following five headings: Background, Aims, Method, Results, and Conclusions. Include up to six key words that describes the article.

b. Main Text. Following APA guidelines, this should contain the sections *Introduction* (including overview and theoretical background), *Method* (participants, design and data analyses), *Results* (described in detail with summary figures and tables), *Discussion* (including conclusions and limitations).

c. Required Sections

Acknowledgements

You may acknowledge individuals or organizations that provided advice, support (non-financial). Formal financial support and funding should be listed in the following section.

Ethical statements

All papers should include a statement indicating that authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the APA http://www.apa.org/ethics/code/. Authors should also confirm if ethical approval was needed, by which organisation, and provide the relevant reference number. If no ethical approval was needed, the authors should state why.

Conflict of Interest

Please provide details of all known financial, professional and personal relationships with the potential to bias the work. Where no known conflicts of interest exist, please include the following statement: "(Authors names) have no conflict of interest with respect to this publication".

Where conflict of interest, ethical statements and acknowledgements would compromise blind review, these may be anonymized from the main manuscript, but should be included in full on the separate title page which is not seen by reviewers. During the review process within the main text it is acceptable to replace identifiable information by using XXXXXX or similar.

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Book:

Tharp, R. G. and Wetzel, R. J. (1969). *Behaviour Modification in the Natural Environment.* New York: Academic Press.

Book Chapter:

Roskies, E. and Lazarus, R.S. (1980). Coping theory and the teaching of coping skills. In P. O. Davidson and S. M. Davidson (Eds.), *Behavioural Medicine: Changing health lifestyles* (pp. 38-69). New York: Brunner/Mazel.

Manual, Diagnostic Scheme, etc.:

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Authors are encouraged to make use of referencing software packages (e.g. Endnote, Mendeley, Reference Manager etc.) to assist with formatting - extensions for APA formatting are easily accessible. However, you are also reminded to check citations and reference lists in detail and not to rely on software packages to format references correctly.

Detailed guidelines on the APA citation and referencing style can be obtained online from sources including the via the Writing Center of the University of Wisconsin–Madison.

e. Footnotes. The first, and preferably only, footnote will appear at the foot of the first page of each article, and subsequently may acknowledge previous unpublished presentation (e.g. dissertation, meeting paper), financial support, scholarly or technical assistance, or a change in affliction.

3. Tables and Figures

Manuscripts should not usually include more than five tables and/or figures. They should be supplied as *separate files*, but have their intended position within the paper clearly indicated in the manuscript. They should be constructed so as to be intelligible without reference to the text.

Figures. Tints and shading in figures may be used, but colour should be avoided unless essential. Although colour is possible in the online version, when designing a figure please ensure that any line variation/distinction demonstrated by colour can still be noted when in black and white. Colour figures are free of charge for online published articles but if authors wish figures to be published in colour in the print version the cost is £200. Numbered figure captions should be provided. All artwork should be submitted as separate TIFF format files.

The minimum resolution for submission of electronic artwork is:

- Halftone Images (Black and White Photographs only): 300 dpi (dots per inch).

- LineTone (Black and White Photographs plus Line Drawings in the same figure): 600 dpi.
- Bitmap (Line Drawings only): 1200 dpi

Please follow this link for full guidance on artwork.

Tables should be provided in editable Word format. They should be numbered and given explanatory titles.

4. Appendices. If any, are intended for inclusion in the printed version of the manuscript and should be kept to a minimum. Please consider the use of supplementary information instead.

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Where unpublished material e.g. behaviour rating scales or therapy manuals are referred to in an article, copies should be submitted as an additional document (where copyright allows) to facilitate review.

Supplementary files can be used to convey supporting or extra information to your study, however, the main manuscript should be able to 'stand-alone' as these documents are not published in the printed issues.

Supporting documents are reviewed but not copyedited on acceptance of the article. They can therefore be submitted in PDF format, and include figures and tables within the text. There is no word limit for supporting online information.

Suggested Reviewers

During the submission process, you will be asked to indicate your preferred and non-preferred reviewers, and the reasons for your choices.

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- Please consider early career researchers as well as field leaders
- Please suggest both niche experts and those with wider knowledge of the subject

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- May have personal or subjective bias to your work which disregards the scientific merit
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SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

EMPIRICAL PAPER

Investigating the Co-Construction of Therapy Goals in Cognitive Behavioural Therapy Using Discourse Analysis

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Abstract

Objective: To examine the discourses used by therapist-client dyads when co-constructing therapy goals in Cognitive Behavioural Therapy and how these discourses influence the process of goal-setting.

Methods: Therapy tapes for five therapist-client dyads were examined and goal setting discourse were transcribed. From this, five representative excerpts were selected then analysed using a Discourse Analysis approach.

Results: Discourses related to power, collaboration, expectations of the CBT model and positioning of therapist and client with regards to the task of goal setting were identified. The use of language as a tool for both creation of shared understanding and as a way of undertaking social action was also identified. There was an emphasis within the excerpts on the micro-process within therapy such as positioning, alliance building and showing a shared understanding of different topics, while narratives on what goals should be or look like informing the macro-process within the co-construction process and forming a wider narrative shaping the process undertaken by therapist and client.

Conclusion: Ensuring that therapists have an awareness of the different discourses in use within goal setting and how they influence the process of goal co-construction is important in ensuring an effective goal setting process. Consideration of the different discourses in the goal setting process is not well represented in the research literature with the majority of research investigating the form and content of goals. Explicit discussion of therapy process in manuals of therapy and therapy teaching could be an important factor in ensuring effective goal setting. Future research could further investigate and how these may impact practice is important.

Keywords: Clinical Psychology, Cognitive Behavioural Therapy, Therapy Goals, Therapy Process, Discourse Analysis

Introduction

Overview

Although there is research suggesting the importance of goal setting and the association between different types of goals and goal attainment (Elliot & Sheldon, 1998), as well as a link between goals and mental health (Schulte & Eifert, 2002), there is very little research investigating exactly how goals are constructed within a therapy session. That is to say, how therapy goals are co-constructed by the therapist-client dyad. Given that qualitative approaches are a good fit for investigating therapy processes, an approach of this type would be a suitable way to address this gap in the research. Given the emphasis on co-construction, a social constructionist method that can analyse therapist-client discussions is indicated. Discourse Analysis (DA) fits this requirement well and is the analytical framework chosen in this study. This introduction will therefore focus on the DA approach and how this links with psychological research, specifically that with a clinical focus.

Principles of Discourse Analysis and Discursive Psychology

DA is an approach that is widely considered to be based within the social constructionist framework (Potter, 1996). Social constructionism can be defined as a concern with the process by which human ability, experience and knowledge are produced within, and consequently reproduce, communities of people (Shotter & Gergen, 1994). Simply, it is an approach concerned with how ideas and understanding are co-created by groups of people, with the implication that meaning and reality is a construction based upon this. DA is concerned with talk and text as a social practice, and on the structures of meaning that are drawn upon in those practices (Potter, 1996). In practice, DA is a diverse field with several different approaches (Wetherall, 2001) which principally focus on the use of language in constructing meaning and undertaking social action, within wider systems of meaning,

(discourses; Georgaca & Avdi, 2012). DA as an analytical process is described in more detail in the methodology section of this paper.

Discursive psychology is a field of psychology that is concerned with the natural interactions of people, i.e. the actions of people in a "live" situation. Typically, this naturalistic approach takes the form of audio recordings of interactions between people and it is principally concerned with how speakers construct, understand and display psychological issues and constructs (Potter, 2003). Of note, discursive psychology can take a fundamentally different approach to understanding psychological phenomena: instead of beginning with inner mental processes as causal or explanatory factors for spoken language, such as the cognitive psychology approach might, discursive psychology is more interested what someone might be doing by saying certain things (Potter, 2003). It is therefore interested in natural language as the moment by moment process of construction of understanding.

Discursive psychology and DA are well matched and many research papers that are concerned with psychological research from a discursive perspective state that DA is the method used for this (Edwards, 2005).

Discourse Analysis of Therapy Sessions

There are relatively few studies that use DA and other qualitative social constructionist methods to study processes in therapy (Avdi & Georgaca, 2009). Research that has been conducted has looked at various processes, ranging from how meaning can be transformed over the course of therapy (e.g. Burck et al., 1998) to how subjectivity and agency is represented in therapy sessions (Avdi, 2005). The features of research conducted to date includes the focus on the micro-processes within therapy and how they influence different discourse and constructions within the therapeutic space. Family therapy is a modality that features heavily within this literature base, as it is closely aligned with DA in terms of its philosophical approach (family therapy is social constructionist). Studies that use

DA to examine CBT sessions are poorly represented in the literature, despite the importance of process issues in therapy.

It is of note that DA literature differs from the clinical literature in how it emphasises the role of choices being necessarily co-constructed socially, which is to be expected given the above descriptions of discursive psychology and DA. There is therefore tension between the clinical and DA perspective when it comes to examining goals. This will be considered further in the discussion section of this paper.

More generally, therapy (in a dyad between client and therapist) that follows a semi-fixed process utilising common techniques, such as CBT, relies on the co-construction of concepts towards a fixed end-point (Dryden & Branch, 2011). This process is achieved through discourse between client and therapist and is variously influenced by factors ranging from personal experience, to the demands of the therapeutic model, to the expectations of society at large (Chantler, 2005). In order to explicitly capture and analyse this range of influences, this project will approach the process of goal-setting from a Discourse Analysis (DA) perspective.

Using DA to investigate CBT

An important point to consider is the match between CBT and discourse analysis. As previously mentioned, the discursive psychological approach (underpinning DA) is a different way from understanding people's actions from the cognitive approach (more associated with CBT). CBT as a theoretical approach bases many different models of treating mental health difficulties on information from cognitive research. However, it does not privilege the cognitive approach as the only method of understanding reality and incorporates many ideas and techniques in the therapy process that can be viewed as being more social constructionist in nature. One example of this is the importance of the person-centred approach in CBT. The person-centred approach refers to a broad style of understanding and

collaborating that is characterised by giving the therapy client the space and control in being able to say what their experience and reality of a situation is. Further to this, building formulations within CBT uses a cognitive basis but the nature of things is determined and decided collaboratively through co-construction.

Furthermore, when it comes to co-construction in the therapy room, the content of CBT and the cognitive approach itself is a topic of conversation and the understanding of CBT is explained through the term "socialisation" to the model. This speaks to the process of establishing a joint understanding and as such the cognitive approach and content of the model can be seen as a narrative structure in a DA approach.

In sum, DA is a good fit for CBT as CBT is not solely concerned with the cognitive approach, but how that approach is negotiate, agreed upon and acted on in the therapy room. This is often considered to be therapy process but is equally important to the theory underlining the models and approaches itself.

Therapy is a process of establishing

Summary

I will focus on the formation of goals. I am specifically interested in how therapy goals are discursively co-constructed between a therapist and client within a CBT therapeutic approach. There is currently little literature giving insight into how therapy goals are constructed in a session and how this process relates to established predictors of goal efficacy. Understanding this process is crucial in a therapeutic context as the type of goal formed is thought to impact therapeutic outcomes (Beck, 1979).

Aims

The aim of this study is to explore how goals in CBT are co-constructed by the therapist and client using discourse from the therapy sessions as data and using DA as an analytical framework. The following questions will guide the analysis:

1. How is a goal and the process of goal setting introduced in a session?
2. Once a concept for goal and goal-setting is agreed, how is the content of a goal or goals agreed?
3. How is a consensus reached that the goal setting is complete?

The following questions are supplemental to the main research questions and will be considered alongside the primary research questions:

- How is the concept conveyed and its importance / necessity justified by the therapist and how is this acknowledged or challenged by the client?
- Are techniques such as SMART goals introduced?
- How are the goals negotiated and what narrative techniques do the therapist and client use to express their opinion?
- How are ideas such as approach and avoidance goals integrated into the discussion?
- What impact does the formation of goals have on therapeutic alliance or the collaborative stance?

Methodology

Design

The study used a discursive psychology approach (Edwards and Potter, 1992), and specifically drew on guidelines from Wiggins and Potter (2008), outlined below This provides a rationale and basis within establish research literature with which to examine the discursive co-construction of psychological concepts and has been used to study qualitative data from therapy sessions (a naturalistic setting).

Data Collection and Ethical Considerations

This study used audio recordings of CBT therapy sessions from the Mood Disorders Centre AccEPT clinic in Exeter as the data pool. Therapy sessions took place between 2015

and 2018, and were conducted by expert therapists. Therapy duration ranged from eight to 24 sessions. Sessions lasted one to one and a quarter hours. Opportunistic sampling was employed: therapists identified session tapes in which goal setting was taken and passed these on to the researcher.

The study aimed to select tapes from five sessions involving five different dyads in total. Six sessions were screened and five were selected as appropriate. The sixth was discarded as the goal-setting discourse in the tape was unclear according to the criteria set for identifying goal setting (see below). Therapy sessions had been recorded for clinical, training and research purposes. Only clients that had provided informed consent for the use of their data in research were identified. Following this screening by therapists at the clinic, the researcher took informed consent from the therapists for these sessions to be used in research (as it had not been taken at the time). The study obtained ethical approval from the NHS Research Ethics Committee and the protocol (Appendix A) and methodology was approved by the Lived Experience Group (LEG) at Exeter University.

Screening and Goal-Setting Transcription

The following criteria were used to decide if goal-setting discussion was occurring: explicit mention of goals or goal setting; discussion about long-term change that a client wants to achieve; discussions about changes that a client wanted to see resulting from therapy. In order to be classed as a goal-setting discussion at least one of these criteria had to be met. The aim of these criteria was to standardise the process of identifying goal setting and to differentiate this from wider discussion about changes a client would like to see unrelated to trying to formalise these changes or think about them in relation to the therapy (i.e. more general change talk). I did not use indicators from the literature on goal-setting in CBT (such as a mention of SMART goals) as I did not expect to see the therapists follow a scripted way of approaching goal setting and this may therefore exclude some instances of goal-setting.

The initial sessions where goals were set were chosen for this study in order to provide a focus around co-construction; the review or setting of subsequent goals later in therapy was not of interest to this research as much as the initial co-construction of goals within the first sessions.

The entirety of each recorded session was listened to by the researcher, with a note of the times that goal-setting discourse was occurring. These timings were checked with reference to the criteria for goal-setting and transcripts of these periods of goal setting were made using Jeffersonian transcription. The discussion of goals occurred with some pauses and digressions to other topics. These periods were not transcribed or analysed as they did not meet the criteria for goal setting discourse. All participant identifiable information was altered to protect participants' anonymity. This included mention of key life events and professional occupations alongside names, dates and addresses. To ensure a rigorous level of anonymisation, all the transcript extracts used in analysis were passed on to the clinicians at the MDC for approval.

Selection of Extracts and Method of Analysis

The selection of the extracts and the methodology used to analyse them are related and will be discussed together. When using a DA approach, it is important to consider the validity and reliability of the analysis, as well as the influence of the researcher on the process of analysis (Jorgensen & Phillips, 2002). Validity and reliability of analysis is measured against the standards of "coherence" and "fruitfulness" (Potter & Wetherall, 1987). Coherence means that the analysis should highlight how discourse and discursive structure fit together to influence the investigated phenomenon (in this case, co-construction of goals). Fruitfulness talks to the novelty and relevance of the findings to DA and the research / clinical context around the analysis. From a methodological perspective, these criteria were adhered to by reviewing transcribed events with these criteria in mind and selecting extracts

based on these criteria and evaluating preliminary analysis based on this. The extracts and analysis were also reviewed by the research supervisor to ensure adherence to these criteria.

Within DA, the emphasis is on the role of language in the construction of a social reality and as a tool of social action (Georgaca & Avdi, 2011). DA therefore examines how phenomena are constructed in verbal accounts and explores the rhetorical function of discourse while placing it within a wider context driven by external systems of meaning (Wiggins & Potter, 2008). Discourses entail subject positions; the discourse shapes not only the construction of the content but also shifts the identities of speaker and recipient, including expected or implied consequential actions. This means that influences on positions and positions established within dyadic, community and societal norms are of relevance to DA, as is the concept of power in privileging constructions, functions or positions in shaping discourse. In other words, it is not only the content that is shaped by discourses, which can come from individuals and communities, but the identities of the speakers too, all of which are important in DA.

Georgaca and Avdi (2011) conceptualise the above through the use of five "levels" at which discourse analysis can occur (see Table 1). In this research, the clinical implications and explicit co-construction of goals was of interest and factors such as narratives from research about what goals look like (level 3), as well as therapist and client concordance and rapport (levels 2 and 3) were identified from the research literature as important. As such, no levels were privileged in this analysis, as, for example, a concept such as rapport and concordance are dependent upon multiple levels interacting to shape the overall discourse (such as constructive discourse, rhetorical strategies and positioning).

On a practical level, DA requires a period of "immersion" in the extracts (reading and re-reading) and an iterative process of selection, analysis and revision in the light of the

criteria for reliability and validity, alongside a reflection on personal position and potential bias. This also formed a part of the analysis.

Table 1. *Conceptual levels of process within Discourse Analysis, adapted from Georgaca and Avdi, 2011*

Level and name	Description
Level 1: Language as constructive: discourses	Analysing discourse to identify how language constructs the objects to which it refers to, in interactions this can include how objects or concepts are negotiated.
Level 2: Language as functional: rhetoric	Analysing the dynamics of the conversation in order to examine how language manages and influences interpersonal functions and how speakers give themselves credibility or reliability
Level 3: Positioning	Examining the way in which identities are formed in relation to the specifics of the interaction and the wider discourses in societal structures
Level 4: Practices, institutions and power	Analysing the interaction between discourses and dominant narratives (which can often be taken for granted) and how these can influence power and resistance
Level 5: Subjectivity	The effects of discourse on how subject positions influence the way they think, feel and experience themselves

Validation of Analysis: DA Peer Review Process

Although the breadth of analysis allows a holistic and comprehensive exploration of the discourses, in DA it is necessary to balance this with a depth and rigour, alongside the overall form of the research (readability and level of reader engagement; Brinkman, 2012). This was achieved through the attendance of a DA interest group at the University of Exeter. In the case of this study, some of the excerpts used and the approach to analysis was reviewed and commented upon by a group of eight researchers (a mixture of doctoral students and post-doctoral researchers with a range of experiences and expertise in DA). This group also leant their insights to the analysis of the excerpts and some of this material has been incorporated into the analysis.

Analysis

Location and Identification of Goal Setting Discourse

All the recordings used were of the second session and the transcription of the sessions was strictly limited to the goal-setting discourse. Initiation of the goal setting discourse was predominantly by the therapist (on four of the five occasions). In total, there were eight periods of goal setting discourse. The total length of goal setting discourse for each dyad ranged from 11 to 25 minutes.

In the following section I present five extracts from the eight periods of goal setting discourse. The extracts were chosen by selecting representative and meaningful sequences of discourse (Jorgensen and Phillips, 2002); i.e. discourse that showed features of interest to the analysis based partly on both DA theory and the literature on goal setting. Extract selection was also informed by the literature review that accompanies this paper, and my own experiences of being a CBT therapist. This is discussed in the discussion section. Given the quantity of the data and the word limit of this paper, analysis of each extract focuses on one or two key points.

Following DA best practice, the analysis will be presented with relevant references to research literature, to provide a coherent and robust narrative to the analysis.

Extract 1: Constructing Goals from Problem Talk and Use of Positioning

The first extract comes from the mid-section of the second session of Amie's CBT. It comes after a long discussion about how Amie's week has been, a bridge from the previous session. They talk about the homework which was to track the things that make Amie anxious. Prior to the beginning of the excerpt, the therapist signposts Amie to the idea of setting goals for therapy, which is introduced through the CBT technique of the agenda for the session. These are introduced as something that Amie would like to see change in over the next four months. Amie has been talking about difficult family dynamics and the therapist is summarising what they have heard about Amie's desire to not want to offend people.

Extract 1. *Amie*

74 T I mean none of us wants to offend people
75 C No no
76 T But getting anxious about the very possibility that you might
77 C Yes and I've even said that in one thing here one one day about – erm - somebody calling
78 bye bye to me in the carpark and then I went away thinking oh I should have said bye first
79 and I just thought this is crazy you know I ((laughs))
80 T Ok so you're spotting it
81 C Yeah
82 T So so if that would that is that a goal that you feel would be meaningful for you?
83 C Yes yeah
84 T To be able to go around your day to day living without getting anxious about the possibility
85 of offending people
86 C Yeah

The extract begins with the therapist normalising the anxiety about offending people (74) and uses the collective "us" to draw therapist and Amie together. This challenges the

typical subject positions in medical discourse (Wilce, 2009) and re-emphasises the position of CBT as a therapy that understands mental health as a function of normal processes, thoughts and reactions that can become emphasised and lead to emotional and functional impedance (Johnstone & Dallos, 2013). Indeed, the therapist uses a qualifier ("none of us wants to" line 77) to indicate that it is the imagined potential for offense triggering anxiety, as being the part that is problematic. This statement is used by Amie to join the therapist in her position by elaborating on an example that demonstrates that (77-79) and the laughter could be an invitation to mutual feeling and could be indicative of a reactionary movement away from the narrative of stigma of anxiety and illness. It also allows a demonstration of how Amie is both able to experience the thought as the reality and to see it from a different perspective (79, "this is crazy you know"). The therapist is quick to reinforce this and shape the shared understanding of the possibility of the different perspective as being important (80).

On Amie's confirmation of this shared point of understanding "Yeah", "Yes, Yeah" (81, 83), the therapist reintroduces goals as a topic of conversation and in doing so links the unit of discourse back into the macro-structure of this part of the conversation: "…is that a goal that would be meaningful for you?" (line 82). This technique is pro-active and it suggests that the therapist sits in the position of controlling the global coherence of the narrative (Morris & Chenail, 2013), but at the same time responding to the micro-level segments of discourse so as not to use power to suppress or alter the shared narrative in a non-flexible manner (82). Indeed, the use of inflection and asking about Amie's feelings and how meaningful she would find this goal is a strong indicator of holding a collaborative stance and the non-expert position; by privileging her perspective and opinion it shifts the power away from the therapist and promotes the idea that the Amie's position is important and to be respected, a common feature of collaboration within therapy (Bennett-Levy, McManus, Westling & Fennell, 2009). From this point, the therapist uses a summary

statement to construct the shared understanding of the goal (84). Although the language is her own, the therapist emphasises the key aspects: the want to decrease anxiety, and how the anxiety can be out of the blue in normal situations. Summarising explicitly gives this understanding back to the client in a non-definitive way and invites agreement or discord and is a common feature in therapy to build collaboration (Wills, 2012). However, it can also be said that the last three turns in the conversation by Amie, although agreeing with the therapist, does so only minimally and could be seen as counter-evidence to the conclusion that the goal is collaboratively co-constructed.

Extract 2: Using Socratic and Direct Questioning to Co-Construct Approach Goals

This extract is taken from towards the middle of the second session for Beth and her therapist. It comes after a discussion about Beth's week and her understanding of what they covered in the last session. Prior to this extract, the therapist has reintroduced goals as something they spoke about briefly in the previous session. The goal setting event is characterised by the stance that the therapist takes in order to follow the guidelines in CBT for setting approach goals and how this agenda is pursued despite some reluctance from the client.

Extract 2. *Beth*

6 C I'd like it to be a lot more reasonable
7 T Ok - mind if I make a note of this?
8 C No
9 T Ok so you want to try and be more reasonable
10 C Yeah
11 T °Mm hm°
12 C Don't fire off at the slightest thing really
13 T Ok so so - if I were to ask you for what that would look like - one thing it would look like
14 would be that you wouldn't fire off at the slightest thing
15 C No

T What would you be doing instead? Because it is easy to tell us tell yourself what we wouldn't do what we shouldn't do but it's harder to say what would you be doing instead – so if something someone's annoyed you instead of firing off what would you be doing?
C (…) Don't know (…) maybe walk out - I don't know (…)
T So being able to walk out
C Walk away from the situation
T Ok
C Yeah
T °Ok°
C So I've not got very many reasoning skills
T And what other things would would show you yourself that you are now more reasonable – what are the things you would be doing that would show you that you are more reasonable
C That people can have a conversation with me without me blowing
T Ok so it's so it's about the anger kind of
C [Well] it's just the fact that I find reasoning really difficult
T °Mm hmm°
C Do you know what I mean?
T And that reasoning is that when you are angry and emotional or in general? (…) so in general if someone rang you up and said I've got a great offer for you if you
C [No] when I'm a bit low as well I'm really unreasonable
T Ok ok so so what would like to be is when your mood is low what would you like to do?
C Well just deal with it like when I am flowing along (…) I suppose
T And what kinds of things would they be - would they be things with other people like disagreements mostly or
C [Yeah] disagreements opinions (…) ((writing in background)) (…)
T So that is a common one the idea of being reasonable - being able to take a different tack.
C Yeah not be so blunt - I'm terrible
T Ok so being less blunt is there any kind do you have any idea of what you would like to be instead of blunt? Do you have anyone in mind who is erm
C [Making] me blunt - yeah - my mother ((both Laugh))
T I guess I was thinking if you have anyone in mind as a role model of what you would like to be like - like someone - like someone I'm imagining someone who is quite diplomatic
C Yeah my husband, the laid back one yeah I'd be a bit more like him
T And how would you - he's laid back - be more laid back

50 C Yeah he's laid back

The therapist's use of reflection and Socratic questioning (Padesky, 1996) is striking in this extract. Her speech suggests a clear a-priori agenda for how the goal setting discourse process should proceed and there is little discourse in this extract that is not a question or reflection of what Beth has said. However, the parts that are directive and prompting are key to the construction of the notion of what a therapy goal should look like (13-14, 16-18, 26-27). The discourse begins by looking at the problem that Beth would like to change and the therapist reflects this back. The therapist's agenda is implied by the question asked in 13-14 that goes unanswered; Beth's response does not follow from the question. The therapist's use of a question to ask more directly about what Beth would do as opposed to not do, which is central to the concept of approach goals (Elliot, 1999), is used to overcome this and re-assert the line of inquiry by the therapist. The therapist signals empathy by talking about what is and is not easier in the situation (lines 16-17). By saying this she is potentially indicating an open-stance and non-judgemental attitude towards this, a key aspect of CBT (Thwaites & Bennett-Levy, 2007). She repeatedly returns to this, continuing the direct questioning about what Beth might do differently ("what are the things you would be doing?" 27; "What would you like to do?" 36). Her talk performs a directive function.

Beth's responses of saying "So I've not got very many reasoning skills" and "don't know", as well as pausing after being asked direct questions indicate that she may be positioning herself here in a compliant role in tune with a power dynamic where the therapist is in a position of authority (Georgaca, 2001). Indeed, a reading of the positioning as a response to the discourse in this extract is that by giving an opinion and driving an agenda with the question, this invites a dynamic which is perceived by Beth as being therapist as expert and her as non-expert. However, the therapist does not enter this dynamic, for example

by making explicit suggestions for goals, and continues to use Socratic questioning to promote the view of the client (Padesky, 1996).

A third important part of the discourse is the construction of meaning around the term "(un)reasonable", which is mentioned by both parties (35, 41). The therapist uses this term, which she heard from the client, suggestive of the verbatim summarising or reflecting encouraged in CBT (Wills, 2012) and crucially the following "reasonable – being able to take a different tack" changes the clients' wish of not wanting to be "unreasonable" and so subtly changes the goal from avoidance to approach, in line with what research would suggest is effective in goal setting (Elliot, 1999). The discourse takes a shift and in a short period of time, as signified through less pauses, more agreement, mutual laughter and the construction of an approach goal, these could be seen as signifies of rapport or closeness (Pomeroy & Weatherall, 2014).

This extract shows how differing agendas can be reconciled (albeit not fully) to achieve the micro-level conversational aims of the therapy client and the macro-level aims of the therapist, and through this process position and implied power within the conversation can shift.

Extract 3: Goals and Client Perspectives

This extract is taken from towards the end of the second section for Claire and her therapist. It comes after a brief discussion at the start of the session about the goals of the therapy, which both agree to think about after more of an introductory conversation about Claire's background and history. Prior to the extract, Claire identified that she wants to work on her physical activity, being proactive in her life, managing her finances and not focusing on her problems. They run through each of these, with the therapist taking time to operationalise each goal so it can be measured. The goal setting segment in this extract is an example of how a counter-narrative brought by the therapist is discussed, particularly how

therapist and client maintain their relationship in the context of a potential source of disagreement.

Extract 3. *Claire*

159 T Ok – Ok (…) and as I I guess as I look at this and this seems a - very reasonable set of
160 goals to have - I I kind of I err kind of have have two thoughts - on one level this is a really –
161 these are really good things to work towards
162 C [Yeah]
163 T And I imagine if you did these you know that would probably help with how you felt – on
164 the other hand - I guess there's a bit for me that's a bit wary
165 C °Mm hmm°
166 T And this is no reflection on your goals - this is just a bit of a thing that I would say to
167 anybody - I guess a part of me that would be wary about holding these up as standards that
168 you would have to attain? Because - erm I wonder if there's something in there about when
169 you don't manage these things how you manage that
170 C Mmm
171 T If you talk to a friend and you come away and think err I spent most of that complaining I
172 wonder if there's something about when that does happen - being able to be ok with that?
173 What do you think of that?
174 C Mmm - yeah that would be good
175 T So I guess there's a bit of a tension in here I guess in anything like is there is a tension
176 between yes I want to work towards things being better in this respect - but at the same time
177 being able to accept when I'm not able to do that?
178 C Yeah
179 T Yeah -
180 C °Mmm°
181 T Is that do you spend some time beating yourself about I spent ages talking to my friend I
182 don't work hard enough I don't put enough in - err another meal I haven't planned -is that?
183 C Yeah -
184 T Yeah
185 C Yeah definitely
186 T Yeah

187 C Mm hmm
188 T Yeah - so we might - kind of in a funny way look at that as well?
189 C – Yeah

The start of the extract begins with the therapist being in an active role, giving an opinion to Claire about the goals they have set so far. The therapists' use of uncertainty and repetition of words implies an attempt to maintain the rapport on introducing a contradictory point of view and trying hold a non-judgemental and empathic position, in line with CBT protocol (Johnstone & Dallos, 2013). The discourse at this point (159-169) is dominated by the therapist and conveys the attempt of the therapist to introduce a new perspective to view the goals from. There is an explicit emphasising of the positivity: "very reasonable" (159); "really good to work towards" (161); "I imagine if you did these, you know that would help you with how you felt" (163), implying an effort to reinforce the positive aspect of the goals; the therapist is trying to introduce a new perspective whilst staying attuned to the client's perspective and in doing so remain in a non-directive position.

Claire responds to the therapist's intervention at this point by agreeing verbally frequently, but also in a minimal way through the use of single word affirmations "yeah" (162), "Mhmm" (165). This implies that she is accepting of what the therapist is saying, but she is not contributing to the discourse at this point. The therapist is using more questions and increases their level of discourse; the therapist dominates the discourse throughout lines 166 to 182. This could be a strategy to try and draw out further response from Claire. There is then a change in pace as the therapist repeats back the "yeah" statements to Claire, indicating a change of tactic that will allow Claire to take control of the discourse, lines 178, 184, and 186. This leaves a clear opening for Claire to contribute to the discourse, which is not taken up; she repeats back to the therapist brief affirmations (lines 179, 185 and 187). Hesitation and these simple statements could indicate a discordance with the therapist.

Claire is positioned here in a passive role by the therapist's dominance of the discussion. However, the lack of speech from Claire limits how the co-construction of goals is achieved through this conversation, although she does passively agree to the therapists' suggestions: this could be an example of therapy goals that are mutually agreed to a lesser extent (Elliot & Church, 2002). It could be said that the therapist shows a control and power over the course of the conversation and the construction of a therapy goal, but equally Claire is in control by cutting short narratives and not sharing her perspective through the use of words; it is difficult to tell who is in control of the narrative. Indeed, there is no clear construction of a therapy goal in this segment. The therapist has the positional power and task power in this situation, but Claire has the personal power to halt or arrest the narrative, which is expressed via the use of minimal language.

This use of minimal language as a potential sign of "therapeutic resistance" (Leahy, 2008) could come about due to the dominant cultural discourse of having to agree with those in a professional stance: it could be the case that it is easier and more culturally acceptable to agree passively than it is to openly challenge the dominant discourse (Georgaca & Avdi, 2012), indeed, the formulation of discord as "resistance" reflects how the dominant discourses around therapy put the therapist in a privileged position. In sum, the extract affords an opportunity to look at how discordance manifests in discourse and how the dyad work through this issue to achieve the task of goal-setting.

Extract 4: Dominant Discourses and Rapport

This extract is set during a goal negotiation which opened with discussion about what the client, Dani, would like to see change in her life over the next few months. There has been previous brief discussion about goals, as well as an acknowledgement of how depression and withdrawal can impact achieving them. This goal setting event is marked by

the therapist encouraging Dani to break up her goal into smaller chunks and using wider narratives to emphasise this action and hold a position of task power.

Extract 4. *Dani*

74 C Erm some of the things well the biggest things would be to start socialising again
75 T Yep
76 C For me to make that connection back with my friends
77 T [Yep]
78 C Erm particularly my best friend is getting married in August and I've not even met her
79 future husband
80 T Yep
81 C Which really bothers me
82 T [Yep]
83 C And I know that that is quite a big thing and there is lot of little things that need to be done
84 to build up to that in terms of getting in touch with people
85 T [Yeah]
86 C Erm being able to actually physically have the energy to spend the time out of the house
87 and spend the time conversing with people - erm and then things like picking activities to do
88 or seeing more than one friend at one time so there are lots of little steps to
89 T [Ok] brilliant so what you're doing there so in terms of setting goals what we know tends to
90 help is - first of all to be very specific and it sounds like you have a a clear goal which is
91 your best friend's getting married in August and is it that you want to meet her partner
92 before or or is it that you want to go to the wedding or or
93 C [No] they're getting married in Greece
94 T Ok so ((both laugh))
95 C But I'd like to meet him
96 T Yeah
97 C Just because erm well yeah she's my best friend
98 T [Yeah]
99 C And we've been best friends since school
100 T Yeah
101 C Erm it's a big part of her life that I feel that I've had no involvement in at all
102 T Yeah brilliant so you've got this goal and you've realised that you got a lot of mini steps

that get you there erm have you erm we sometimes talk about setting out the hierarchy of steps where you start out with the less ambitious ones and get comfortable with those and then you move up to the more ambitious more anxiety provoking ones and you gradually go up go up there so for the ones you talked about there of erm getting in touch with friends – choosing activities being in a group how would you - how would you start to rank those in in how anxiety provoking they'd be for you?
C It would be the less attached things so
T [Yeah]
C So the less face to face things would be the easiest things
C Yeah
T And then building up to the hardest things would be the one on one or one within a group erm - you know for any time of extended period of time
T Yeah so is one on one easier or is group is group easier for you?
C One on would be easier to start with
T Yeah
C Erm and then (…) then group I think

The extract starts with Dani being in the position of telling the story of why a particular goal is important to her (74), and she is starting to analyse the difficulty with this goal and look at its components unprompted (86-88). Crucial to this extract, at the point Dani says "little steps" the therapist chooses this time to interject and add a frame of reference to the process she is going through (89-90). The use of the term "we" indicates a shift of position for the therapist and the use of the narrative from CBT about how goals should look (Michalak & Grosse Holtforth, 2006). The use of the "we" explicitly positions the therapist with a position of authority and from this position shifts to a place of controlling the narrative and is tactic used in CBT to imply a shared agenda (Wills, 2012). Dani is quiet at this point and the therapist goes to hypothesise about the situation and frame Dani's discourse about the wedding using his own frame of reference (90-92). Dani firmly cuts back into the narrative here ("no", 93) and gives a piece of contradictory information "they're getting married in

Greece" (93). At this point, both laugh. This implies that despite the to and fro with control of the narrative both therapist and Dani have a strong rapport, indeed, presumably the laughter is about the suddenness with which the strong narrative from the therapist is cut short. This hands the conversation back to Dani, who goes on to elaborate. Interestingly with this part of the extract, it is an example of how conflicting narratives, although in this case a minor one, can be resolved and shows the rapport of therapist and client can influence this, regardless of the content of the discourse.

On line 102 the therapist re-asserts a dominant narrative position by summarising and praising, which suggests an unbalanced power position where the therapist is interpreter and the client is passive. Indeed, use of terms such as "you've realised" indicates a privileged position of the therapist, but in a way which is ambiguous: it could both be inclusive or coercive. The use of terminology and specialist language (e.g. "hierarchy of steps") well known in CBT goal-setting cements his position. The use of a question requires Dani to construct her experiences and goals through the frame of interpretation provided by the therapist. The rest of the excerpt continues this line of conversation: Dani accepts the invite to order her experiences and expectations in this way and does so. Her use of two examples and putting them into a relative position with the therapist's help suggests that she is understanding this instruction, as does her use of similar language ("and then building up" 112). This could be a demonstration of how clients learn to use language and talk in a therapeutic framework about their issues.

Extract 5: Medical Discourses and Change Talk

This extract is from the start of the second session. The client, Emma, is talking with her therapist about her experience of mixed episodes as part of her bipolar disorder diagnosis, and how this relates to the idea of what her goals for the therapy will be. Emma identifies that she would like to be in control of her moods and her dialogue thus far with the therapist is

about the difficulties that she has, including examples. The extract is a representative example of how the therapy dyad are navigating ideas of change and agency as a result of the task of setting therapeutic goals.

Extract 5. *Emma*

94 T Ok so there's so there's something that's going on at the time - kind of uncomfortable
95 buzzy state that you're less aware of what's going for than than you'd like to be and you'd
96 like more insight into where he's coming from
97 C Yeah
98 T Would you say that the conflicts you get into are nearly always about your mood when it's
99 going up or is there more general conflict about other areas that
100 C [Yeah] ((sigh)) I think we always fall out over me having ideas that he doesn't agree with
101 T °Mmm°
102 C Because he often thinks that my ideas are a symptom of not being well and it's not always
103 that its pure enthusiasm and so we - the biggest arguments we've had are when I've started
104 new projects that he doesn't agree I should be doing
105 T Ok so your pattern is when you're in that productive mildly upset phase you're full of ideas
106 and take things on and some of those are really good ideas but he's seen enough of them in
107 the past that he puts them all
108 C [Yeah] most of them I mean we went and looked at a car this week that was ridiculously
109 cheap and could be a good project and I was looking at where I could do this and how I could
110 do that and he just - absolutely no we're not doing that it's too much
111 T °Ok°
112 C Ermm and I think it's a brilliant idea and I guess because a not I've I've learnt I will never
113 ever ever ever go ahead with a project unless I've got his one hundred percent if it's a joint
114 project unless I've got his one hundred percent backing because he is such a right royal pain
115 in the arse if it's a project that he does that he doesn't agree with everything is a problem
116 nothing is solvable everything is I told you not to do this
117 T °Ok°
118 C ((Laughs)) and in fact almost makes sure it fails because he's so negative about it - so erm I
119 had to just drop it but in days gone by we would have fallen out over that
120 T Ok so I think a task for us in coming sessions is to find a way to get really precise about

what needs to change about - your relationship with Dane needs to change so you can support one another but I don't think we're there yet as we can't understand it fully so let's let's put that as a find ways to support each other rather than get into conflict
C °Yeah°
T Um what do you think about the idea that um Dane thinks you take too much stuff on do you think there's any merit in that or or do you think it's that?
C I definitely do tend to take too much stuff on but it's like I guess the analogy is that if you're really desperate to have a book that engrosses you you might have to have five books on the go at once to find out which one becomes the page turner - I guess I operate my life like that so I will start a million things and see which one has the legs and flies - oh that's terrible ((laughs)) legs and flies but you know what I mean which one takes off and which one ends up being the thing we do and I I do that in every area of my life whether it's a drawing project or choosing new plants for the garden or erm yeah
T So it's a bit like - err you chuck fifteen balls into the air and see which ones stay up in the air keep juggling keep you entertained

The extract begins with the therapist summing up some of what they have been speaking about, with the latter half of his sentence (95-96) framing this into a goal. Starting at 100, Emma starts to control the narrative by explaining in detail an example of conflicts that she gets into (102-126). There are clear examples of how medicalised discourse around mental health influences the dialogue at this point and both Emma and the therapist take part in this "he often thinks my ideas are a symptom of not being well" (102, Emma) and "mildly upset phase" (105, therapist).

The therapist through this phase of the dialogue could be in a position of low agency in the conversation, as indicated through the use of affirmative statements that are at a lower volume that Emma (111, 117, 124). Indeed, Emma cuts across the therapist to continue her narrative and this could be seen as an example of how she is trying to argue for the validity of her perspective within her relationship (108).

The conversation about Emma's experience with projects and Dane's approval up to line 120 runs counter to the agenda of the therapist, which is to formulate a goal. The therapist then makes a clear statement to take back control of the dialogue and assert this agenda by providing a clear statement of intent (120-121) and a clear control over the interpretation of the conversation so far "your relationship to Dane needs to change so you can support one-another". As in a previous extract, the therapist uses the authority of position and taps into the narrative of therapists and healthcare professionals as holding expertise by stating "I don't think we're there yet as we can't understand it fully". The therapist then indicates that they are interested in forming a symptom goal (Ryum et al., 2014) "what do you think about the idea that you take too much stuff on?" (125-126). Emma does not directly answer this question but instead uses an analogy (127-133), which the therapist joins (134-135). The use of analogy by Emma could be viewed as a rhetorical device (Wodak & Meyer, 2009) which serves to reinforce her position and view that this is a part of who she is and her identity. The response to this by the therapist indicates a departure from the position that her behaviour is influenced by her mental health ("So it's a bit like - err you chuck fifteen balls into the air and see which ones stay up in the air", 134), and toward Emma's perspective that her behaviour is a part of who she is and pervasive "I do that in every area of my life" (132). This position may hold part of the reason as to why the goal-directed talk is difficult: if Emma is invested in the idea that her behaviours and actions are part of a stable relatively long-term personality trait, then the therapist's position that behaviours and attitudes can be changed may inadvertently put pressure on Emma's construction of her self and her identity. Indeed, the use of the term "entertained" (135) by the therapist may well be indicative of this split, as in tone it is removed from Emma's explanation of values and importance in her life, which is always going to be a significant driver of behaviour, and indeed itself an important part of setting personally meaningful goals (Michalak, Klappheck & Kosfelder, 2004).

Discussion

The analysis of the five goal setting event extracts gives a broad range of findings and interpretations. As noted in the previous section, DA analysis can be viewed as a discursive exercise and can therefore be analysed in turn (Potter, 1996). As such, all findings should be viewed within this context and the generalisability of this research is therefore limited to an extent. It is of note that the analysis was subject to review by the project supervisor, which keeps to the DA criteria of being (valid and representative of content). The extracts are also provided in full, allowing others to review the content and draw parallel lines of inquiry. They provide insight into the moment to moment interactions that are crucial in the co-construction of goals in a therapy setting.

Clinical Practice Implications

Positioning and the collaborative stance. The analysis of the extracts emphasised the use of positioning in not only achieving a co-construction of goals but also building therapeutic alliance. Collaboration and rapport can assist in therapy as it allows the new narratives that therapists introduce (such as alternative ways of understanding and approaching emotion and behaviour) to be more likely to be assimilated into a client's own views and beliefs (DeFife & Hilsenroth, 2011). Indeed, the whole process of goal setting is an agenda often brought by the therapist, certainly this was the case in all the extracts. CBT values collaboration and building an aligned way of understanding someone's mental health problems (Zuroff & Blatt, 2006). It is a core part of person-centred therapeutic approaches in general. In clinical terms, it shows the importance of having a range of therapeutic techniques available and how it is necessary to be flexible. Indeed, this is the essence of drawing together a joint understanding of a person's current patterns of coping with mental health difficulties (termed a formulation in CBT (Johnstone & Dallos, 2013) and a necessary part of CBT. However, it is important to note that this does not mean that there were no tensions in

the therapeutic alliance in the extracts and no challenges to rapport. This will be covered in the following parts of the discussion.

Power and shaping of narratives. Following from the above point, one of the striking parts of the analysis was how power manifested in the co-construction of goals. Power is an important factor in the therapeutic space (De Varis 1994) particularly the potential for one party to hold more power than the other Unlike other psychotherapeutic approaches which place a great emphasis on considering power dynamics in the formulation and treatment of mental health difficulties, CBT does not tap into this as explicitly, although increasingly in CBT for more complex disorders this is being given more emphasis (Basco & Rush, 2005). It is important to note that some CBT therapists, depending on their training, and certain types of CBT may emphasis following a protocol and set series of stages, but there has been criticism of this as rigidifying the process of therapy and not leading to enough consideration of process issues such as the therapeutic alliance (Strupp & Anderson, 1997), despite the established importance of relationship variables in therapy outcomes (Shirk & Karver, 2003) As such, the demonstration by this analysis that power and power dynamics was evident and influenced the discourse, and in particular, was highly relevant to understanding exactly how goals are co-constructed in a therapy setting, emphasises the role of power dynamics. The manifestation of power within discourses across the extracts did not take a particular form or have a set impact on the goal-setting.

Technical language and operationalisation of goals. The above section builds the hypothesis that it is the micro-events (Morris & Chenail 2013) that were very pivotal around rapport and shared understanding, and that the approach emphasised in clinical literature and goal-setting research was influenced, in practice, by these micro-events Indeed, the overall macro-structure of the discussions reflected this in an isomorphic way through their disperse and fluid nature during the therapy sessions. We can see from the identified goal-setting

segments that goal setting was open-ended: it was not always clear when the discourse started and ended, and it would dip in and out flexibly. This may reflect the sophistication of the therapists in following the narrative and being able to switch conversations and come back to points (a marker of high levels of therapist competence; Fairburn & Cooper, 2011). Regardless, it was interesting that the majority of the factors mentioned within the literature review of this thesis were not covered in an explicit way. The way in which goals were co-constructed collaboratively was a prominent feature, compared to using materials or guidance to explicitly guide the process. Clinically, the relevance of this is in the prioritisation or relative emphasis of form and process (taking note of the micro-events), whilst still considering the role of the macro-structure of sessions and use of specific goal-setting tools and standards indicated by therapeutic manuals and research literature. d. At this point, caution to the implications of this should be taken, as this study did not follow the goals set and their "success" (whether defined by meeting pre-specified criteria for what goals look like or goal attainment), so it is not possible to say whether more or less emphasis is needed on certain factors that influence goal-setting over others based on this research alone.

Relevance to CBT and Goal Setting Research

This research is important as it builds on the DA literature within CBT and also adds to the goal setting literature, within which there is very little research using DA. This study reinforces the validity of such an approach and the conclusions from this study strengthen CBT literature by showing how the process in the therapy room can influence goal setting.

This research highlights that, despite the amount of research dedicated to types of goals and goal features, there is a gap between this and the actual practices, the "micro-events", highlighted by close consideration of the discourse in the study, namely the importance of rapport and collaboration. An implication of this study is that an increase in

focus on these factors could have an impact on how goals are formed and their subsequent outcomes.

DA necessarily looks at the role of both the therapist and client. This is a departure from some previous studies on goal-setting, which implicitly emphasise therapist agency in goal-setting by favouring the interpretations and actions of the therapist (Arnow & Castonguay, 1996). It is a benefit over these studies and a development in the literature that this study looks at the actual practices of both therapist and client, rather than interpretations or accounts provided after the therapeutic activity, and considers the act of co-construction and the function of language in attaining this.

Researcher Reflexivity

DA is a deconstructive process and as such the researchers and their own views and preconceptions play an important part in shaping the analysis (Antaki et al., 2003). As a white male trainee clinical psychologist from a middle-class background in a predominantly white-British area, I may have overlooked certain aspects or discursive acts or privileged certain narratives, for example, that of the therapist, which I would more easily be able to relate to given my professional experiences with CBT therapy.

One particular issue, given my academic and clinical background, is that the majority of my experiences to date have been working in a paradigm outside of discursive psychology. For example, the use cognitive psychology, which places more emphasis on the internal motivations and reasons for action, is at odds with the DA approach and analysis which is more neurocognitive or makes assumptions about the internal cognitive mechanisms of the therapist or client would not be valid in the DA approach.

Attending the DA research group and presenting the extracts and my analysis (approach and some of the content) was an opportunity for these shortcomings to be addressed. Through the experience of this group, it was clear that I had, as a clinician with

over five years of experience with CBT, did not emphasis examples of discourse being rooted in CBT methodology or narrative as much as other participants, who found more examples of this. Further to this, the group also highlighted, rooted in the excerpts, how some narratives around power and the expectations of clients going into therapy may be being expressed. The range of experiences and perspectives helped to broaden the insights from the data and were incorporated into the analysis.

Limitations and Future Research

One of the limitations inherent to the DA approach is that of a limited generalisability. This is relevant as it interacts with the features of the therapists in this research. They were highly trained and with several years of experience. The central tenant of the main argument in the analysis and discussion was that goal setting was an activity shaped to a large extent by micro-events concerned with rapport, collaboration, empathy and responding to power and wider narratives, with less explicit language covering the form of goals and common techniques from therapy literature. As such, this effects the generalisability, especially in light of the increasing prevalence of "low intensity" CBT protocols, which are often delivered by therapists with less training, fewer sessions with clients, and more of a need to stick to a protocol. It is the case that the use of more external frameworks to deliver this therapy will lead to a different type of goal setting experience, although the overall therapeutic framework is similar. Future research could therefore replicate this study with therapy dyads engaged in a low-intensity CBT and specifically look at the balance between these different factors in the co-construction of goals.

Outside of the core strand of the argument of this research, there are cultural or external narratives influencing the therapeutic space. Therapies such as systemic therapy encourage the explicit influence of personal and wider narratives on themes such as gender, race, sexuality (the social graces; Burnham, 2018) to be explicitly considered. There was little

explicit discourse concerning this in the transcripts. The more accessible narratives were the medical model and the CBT notion of what goals should look like (extracts). Therefore, future research could examine further attention to cultural variations and awareness of power dynamics in a therapy context, and how this may impact goal-setting activities.

Conclusions

This novel piece of research is the first time in which the co-construction of goals in CBT has been analysed using a DA approach. Some findings, such as the presence of explicit talk about goals and their operationalisation are in line with existing research, whilst others emphasise the importance of process factors such as rapport building and power dynamics as strongly influencing the co-construction of therapy goals. The results emphasise the importance of considering these process factors within the goal setting period and suggests that the consideration of factors such as collaboration and power in the goal-setting process of CBT should be investigated further.

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Appendix A: Letter of HRA Approval

Dr Richard White

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20 April 2018

Dear Dr White

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**An investigation into the co-construction of therapy goals in cognitive behavioural therapy**
IRAS project ID:	**220848**
Protocol number:	**1817/035**
REC reference:	**18/SW/0067**
Sponsor	**University of Exeter**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales*, as well as any documentation that has been updated as a result of the assessment.

*'In flight studies' which have already started an SSI (Site Specific Information) application for NHS organisations in Wales will continue to use this route. Until 10 June 2018, applications on either documentation will be accepted in Wales, but after this date all local information packs should be shared with NHS organisations in Wales using the Statement of Activities/Schedule of Events for non-commercial studies and template agreement/ industry costing template for commercial studies.

Participating NHS organisations in England and Wales will not be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation 35 days following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)
- The NHS organisation has not provided a reason as to why they cannot participate
- The NHS organisation has not requested additional time to confirm.

IRAS project ID	225848

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

If not already done so, you should now provide the local information pack for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose. After entering your IRAS ID you will be able to access a password protected document (password: $pring24). The password is updated on a monthly basis so please obtain the relevant contact information as soon as possible; please do not hesitate to contact me should you encounter any issues.

Commencing research activities at any NHS organisation before providing them with the full local information pack and allowing them the agreed duration to opt-out, or to request additional time (unless you have received from their R&D department notification that you may commence), is a breach of the terms of HRA/HCRW Approval. Further information is provided in the "*summary of assessment*" section towards the end of this document.

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA/HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA/HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

IRAS project ID	220848

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Gail Seymour
Tel: 01392 726621
Email: G.M.Seymour@exeter.ac.uk

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **220848**. Please quote this on all correspondence.

Yours sincerely

Michael Pate
Assessor

Email: hra.approval@nhs.net

Copy to: *Ms Gail Seymour - University of Exeter – Sponsor contact.*

Appendix B: Dissemination Statement

Dissemination Statement

The results of this study will be disseminated to interested parties through feedback, journal publication and presentation.

Dissemination to participants and LEG

The therapists that participated in this research will be sent a summary of study findings by email. They will also be given the opportunity to request a full copy of the write up via email if they are interested. The same protocol will apply to the LEG at Exeter University, who approved the methodology within this research.

Journal Publication

It is expected that the study will be submitted for publication with Behavioural and Cognitive Psychotherapy journal.

Presentation to NHS service

The research findings will be presented to an academic and clinical audience at the joint NHS and University of Exeter clinic from which the data was collected (the AccEPT clinic)

Appendix C: Author Guidelines for Behavioural and Cognitive Psychotherapy

Editorial Statement

Behavioural and Cognitive Psychotherapy is an international multidisciplinary journal for the publication of original research of an experimental, or clinical nature that contributes to the theory, practice and evaluation of cognitive and behavioural therapies. As such the scope of the journal is very broad, and articles relevant to most areas of human behaviour and human experience which would be of interest to members of the helping and teaching professions will be considered for publication.

As an applied science the concepts, methodology and techniques of behavioural psychotherapy continue to change. The journal seeks both to reflect and to influence those changes. While the emphasis is placed on empirical research, articles concerned with important theoretical and methodological issues as well as evaluative reviews of the behavioural literature are also published. In addition, given the emphasis of behaviour therapy on the experimental investigation of the single case, the journal from time to time publishes case studies using single case experimental designs. For the majority of designs this should include a baseline period with repeated measures; in all instances the nature of the quantitative data and the intervention must be clearly specified. Other types of case report can be submitted for the Brief Clinical Reports section.

Articles should concern original material that is neither published nor under consideration for publication elsewhere. This applies also to articles in languages other than English.

Sections of the Journal

Main

Reports of original research employing experimental or correlational methods and using within or between subject designs. Review or discussion articles that are based on empirical data and that have important new theoretical, conceptual or applied implications.

Accelerated Publication

The accelerated publication section is intended to accommodate a small number of important papers. Such papers will include major new findings for which rapid dissemination would be of considerable benefit and impact. For example: reports of the results of important new clinical trials; innovative experimental results with major implications for theory or practice; other work of unusually high calibre. If submitting a manuscript to this section you must specify in your cover letter why it should be considered as Accelerated.

Empirically Grounded Clinical Interventions

This section is intended for reviews of the present status of treatment approaches for specific psychological problems. It is intended that such articles will draw upon a combination of treatment trials, experimental evidence and other research, and be firmly founded in phenomenology. It should take account of, but also go beyond, treatment outcome data.

Brief Clinical Reports

Material suitable for this section includes unusual case reports and accounts of potentially important techniques, phenomena or observations; for example, descriptions of previously unreported techniques, outlines of available treatment manuals, descriptions of innovative variations of existing procedures, details of self-help or training packages, and accounts of the application of existing techniques in novel settings. The BCR section is intended to extend the scope of the clinical section. Submissions to this section should be **no longer than 1800 words** and should include **no more than six references, one table or figure**, and an **extended report** that contains fuller details. There are no restrictions on the size or format of the extended report as it will be published online only. It may, for instance, be a treatment manual, a fully detailed case report, or a therapy transcript. If a submission is accepted for publication as a Brief Clinical Report, the author(s) must be prepared to send the fuller document to those requesting it, free of charge or at a price agreed with the editor to reflect the cost of materials involved. The extended document will also be mounted on the journal's website as a PDF format (the document will not be copyedited).

Study Protocols

Protocols of proposed and ongoing trials in behavioural and cognitive therapies will be considered. Your study must be registered and have ethical approval, and proof of this will be required. The abstract should be **structured** under the following four headings; **Background, Aims, Method, Discussion.**

Please use the *Standard Protocol Items: Recommendations for Interventional Trail* (SPIRIT) checklist for protocols of randomised controlled trials (see the reporting standards section below). Manuscripts should be **under 2000 words** at the point of first submission, and include no more than **15 references**, and no more than **three tables/figures in total**. A PDF with additional, unlimited text, figures and tables may be included designated for online only publication.

Reporting Standards

Behavioural and Cognitive Psychotherapy supports standardised reporting practices, consult the following table to ensure your submission meets the reporting standards for your manuscript type. Please include the relevant supporting information (such as diagrams and checklists) with your submission files. See http://www.equator-network.org/reporting-guidelines/ for more information on manuscript types not described below.

The journal also encourages clarity in describing interventions sufficient to allow their replication through the use of the Template for Intervention Description and Replication Checklist (TIDieR).

Randomised Controlled Trial	CONSORT	http://www.consort-statement.org/
Systematic reviews and Meta-Analysis	PRISMA	http://www.prisma-statement.org/
Study Protocols	SPIRIT	http://www.spirit-statement.org/

Preparing Your Manuscript

Articles must be under 5,000 words at the point of submission, excluding references, tables and figures (please see separate instructions for Brief Clinical Reports and Study Protocols). Manuscripts describing more than one study may exceed this limit but please make this clear to the editorial office in your cover letter.

Authors who want a blind review should indicate this at the point of submission of their article, omitting details of authorship and other identifying information from the main manuscript. Authors who do not omit this information will be assumed as submitting a non-blinded manuscript. Submission for blind review is encouraged.

All submissions should be submitted via this portal: http://mc.manuscriptcentral.com/babcp

Style

APA style should be followed throughout. http://www.apastyle.org/

Abbreviations where used must be standard. The Systeme International (SI) should be used for all units. Probability values and power statistics should be given with statistical values and degrees of freedom (e.g. $t(34) = 2.39$, $p<.001$), but such information may be included in tables rather than in the main text. Spelling must be consistent within an article, using either British spelling (*The Shorter Oxford English Dictionary*), or American (*Webster's New World College Dictionary*). However, spelling in the list of references must be literal to each publication.

In-text references

In-text references should be cited as follows: "...Given the critical role of the prefrontal cortex (PFC) in working memory (Cohen et al., 1997; Goldman-Rakic, 1987; Perlstein et al., 2003a, 2003b)..." with multiple references in alphabetical order. Another example: "...Cohen et al. (1994, 1997), Braver et al. (1997), and Jonides and Smith (1997) demonstrated..."

References cited in the text with two authors should list both names. References cited in the text with three, four, or five authors, list all authors at first mention; with subsequent citations include only the first author's last name followed by et al. References cited in the text with six or more authors should list the first author et al.

throughout. In the reference section, for works with up to seven authors, list all authors. For eight authors or more, list the first six, then ellipses followed by the last author's name.

Details of style not specified here may be determined by reference to the *Publication Manual of the American Psychological Association*.

Manuscripts Should Conform to the Following Scheme

1. Title Page

The title should phrase concisely the major issues. Author(s) to be given with departmental affiliations and addresses, grouped appropriately. A running head of no more than 40 characters should be indicated and carried through the document as a header. This should be uploaded as a separate file.

2. Main Manuscript

a. Abstract. Unless a Study Protocol (see separate guidelines), a 250 word abstract should be structured under the following five headings: Background, Aims, Method, Results, and Conclusions. Include up to six key words that describes the article.

b. Main Text. Following APA guidelines, this should contain the sections *Introduction* (including overview and theoretical background), *Method* (participants, design and data analyses), *Results* (described in detail with summary figures and tables), *Discussion* (including conclusions and limitations).

c. Required Sections

Acknowledgements

You may acknowledge individuals or organizations that provided advice, support (non-financial). Formal financial support and funding should be listed in the following section.

Ethical statements

All papers should include a statement indicating that authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the APA http://www.apa.org/ethics/code/. Authors should also confirm if ethical approval was needed, by which organisation, and provide the relevant reference number. If no ethical approval was needed, the authors should state why.

Conflict of Interest

Please provide details of all known financial, professional and personal relationships with the potential to bias the work. Where no known conflicts of interest exist, please

include the following statement: “(Authors names) have no conflict of interest with respect to this publication”.

Where conflict of interest, ethical statements and acknowledgements would compromise blind review, these may be anonymized from the main manuscript, but should be included in full on the separate title page which is not seen by reviewers. During the review process within the main text it is acceptable to replace identifiable information by using XXXXXX or similar.

Financial Support

Please provide details of the sources of financial support for all authors, including grant numbers. For example, “This work was supported by the Medical research Council (grant number XXXXXXX)”. Multiple grant numbers should be separated by a comma and space, and where research was funded by more than one agency the different agencies should be separated by a semi-colon, with “and” before the final funder. Grants held by different authors should be identified as belonging to individual authors by the authors’ initials. For example, “This work was supported by the Wellcome Trust (A.B., grant numbers XXXX, YYYY), (C.D., grant number ZZZZ); the Natural Environment Research Council (E.F., grant number FFFF); and the National Institutes of Health (A.B., grant number GGGG), (E.F., grant number HHHH)”. Where no specific funding has been provided for research, please provide the following statement: “This research received no specific grant from any funding agency, commercial or not-for-profit sectors.”

d. References. References should be consistent with the *Publication Manual of the American Psychological Association (6th Edition)*.

If a DOI has been assigned to an article that you are citing, you should include this after the page numbers for the article. If no DOI has been assigned and you are accessing the periodical online, use the URL of the website from which you are retrieving the periodical.

Examples of the APA reference style are as follows:

Online/Electronic Journal Article (with DOI):

Kaltenthaler, E., Parry, G. & Beverley, C. (2004). Computerized cognitive behaviour therapy: a systematic review. *Behavioural and Cognitive Psychotherapy, 32*, 31–55. doi:10.1017/S135246580400102X.

Book:

Tharp, R. G. and Wetzel, R. J. (1969). *Behaviour Modification in the Natural Environment.* New York: Academic Press.

Book Chapter:

Roskies, E. and Lazarus, R.S. (1980). Coping theory and the teaching of coping skills. In P. O. Davidson and S. M. Davidson (Eds.), *Behavioural Medicine: Changing health lifestyles* (pp. 38-69). New York: Brunner/Mazel.

Manual, Diagnostic Scheme, etc.:

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Authors are encouraged to make use of referencing software packages (e.g. Endnote, Mendeley, Reference Manager etc.) to assist with formatting - extensions for APA formatting are easily accessible. However, you are also reminded to check citations and reference lists in detail and not to rely on software packages to format references correctly.

Detailed guidelines on the APA citation and referencing style can be obtained online from sources including the via the Writing Center of the University of Wisconsin–Madison.

e. Footnotes. The first, and preferably only, footnote will appear at the foot of the first page of each article, and subsequently may acknowledge previous unpublished presentation (e.g. dissertation, meeting paper), financial support, scholarly or technical assistance, or a change in affliction.

3. Tables and Figures

Manuscripts should not usually include more than five tables and/or figures. They should be supplied as *separate files*, but have their intended position within the paper clearly indicated in the manuscript. They should be constructed so as to be intelligible without reference to the text.

Figures. Tints and shading in figures may be used, but colour should be avoided unless essential. Although colour is possible in the online version, when designing a figure please ensure that any line variation/distinction demonstrated by colour can still be noted when in black and white. Colour figures are free of charge for online published articles but if authors wish figures to be published in colour in the print version the cost is £200. Numbered figure captions should be provided. All artwork should be submitted as separate TIFF format files.

The minimum resolution for submission of electronic artwork is:

- Halftone Images (Black and White Photographs only): 300 dpi (dots per inch).
- LineTone (Black and White Photographs plus Line Drawings in the same figure): 600 dpi.
- Bitmap (Line Drawings only): 1200 dpi

Please follow this link for full guidance on artwork.

Tables should be provided in editable Word format. They should be numbered and given explanatory titles.

4. Appendices. If any, are intended for inclusion in the printed version of the manuscript and should be kept to a minimum. Please consider the use of supplementary information instead.

5. Supplementary Information – Online only

Where unpublished material e.g. behaviour rating scales or therapy manuals are referred to in an article, copies should be submitted as an additional document (where copyright allows) to facilitate review.

Supplementary files can be used to convey supporting or extra information to your study, however, the main manuscript should be able to 'stand-alone' as these documents are not published in the printed issues.

Supporting documents are reviewed but not copyedited on acceptance of the article. They can therefore be submitted in PDF format, and include figures and tables within the text. There is no word limit for supporting online information.

Suggested Reviewers

During the submission process, you will be asked to indicate your preferred and non-preferred reviewers, and the reasons for your choices.

Preferred reviewers:

- Should not have a conflict of interest (such as a recent or current close working relationship, or from the same institution)
- At least half of the list should be international to yourself
- Please consider early career researchers as well as field leaders
- Please suggest both niche experts and those with wider knowledge of the subject

Non-preferred reviewers:

- May have personal or subjective bias to your work which disregards the scientific merit
- May have seen or commented on the submitted manuscript, or prior versions.

Ethical Standards

Behavioural and Cognitive Psychotherapy is committed to actively investigating any cases of suspected misconduct, even in the event of the manuscript being withdrawn. All manuscripts are screened for plagiarism before being accepted for publication. All editors and reviewers are asked to disclose any conflict of interest when they are assigned a manuscript. If deemed necessary, alternative or additional opinions will be sought in order to maintain the balance of fair and thorough peer review.

The journal is a member of COPE.

Retractions

Behavioural and Cognitive Psychotherapy follows the COPE guidelines on retractions.

Transfer Of Files For Submission To the Cognitive Behavioural Therapist

Editors for *Behavioural and Cognitive Psychotherapy* (BCP) can choose to recommend submission of a manuscript not suitable for *BCP* to *the Cognitive Behavioural Therapist (tCBT)*, thus effectively submitting to both journals sequentially. This allows the automatic transfer of the manuscript files, including, as appropriate, transmission of reviewers' comments (at the discretion of the handling Editor) where this seems likely to facilitate manuscript handling. Selection of a manuscript to be transferred to *tCBT*is at the Editor's discretion, and is then subject to the peer-review process of that journal. No guarantee of suitability for *tCBT* or acceptance is made. Those papers not passed on to *tCBT* by a *BCP* Editor can be submitted by the author via the usual channels.

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Author Language Services

Cambridge University Press recommends that authors have their manuscripts checked by an English language native speaker before submission; this will ensure that submissions are judged at peer review exclusively on academic merit. We list a number of third-party services specialising in language editing and / or translation, and suggest that authors contact as appropriate. Use of any of these services is voluntary, and at the author's own expense.

Appendix XXXXX

How the research question evolved

The research question is conceptualised within the body of the empirical paper as a series of guiding questions. This is in line with DA principles of analysing data. It is important to set out with an idea or framework for the analysis that you undertake but not to be restricted or to privilege your a-priori assumptions and interests above what is in the body of the work. The reason for this is two-fold. Firstly, to presuppose the topics of interest and see how they fit the work does not fit the exploratory nature of DA. Secondly, it does not allow for the process of immersion and response to the data in the way espoused by those that practice DA. In practice, in this study the questions were formed based off literature review and consideration of the topic at hand. This of course began with the questions derived from the content of the papers reviewed. The questions began to change and form during the initial listening to the tapes, including how to respond to such questions as “what counts as goal-setting discourse”, “is this interesting or relevant goal setting discourse”. The answers to these questions are not clear-cut. As such reflection and interpretation and therefore analysis itself, began at this point. Further to this, DA holds within its concept of validity the idea or peer review. Peer review was through supervision and group-based review, as described in the body of the thesis. This meant that external narratives and perspectives on the data were introduced, and raised new or additional topics to be discovered. Additionally, the questions evolved throughout analysis and write-up. Consideration of a point across multiple extracts of noticing a link brought new understanding and focus to the work. The expression of this is in the discussion section and is reflected in the fact that the content of this discussion is not something directly pre-empted from the initial guiding questions.